CASE # C15-2010-0055
ROW # 10439594
TP- 024313-1108

CITY OF AUSTIN
APPLICATION TO BOARD OF ADJUSTMENT
GENERAL VARIANCE/PARKING VARIANCE

WARNING: Filing of this appeal stops all affected construction activity.

PLEASE: APPLICATION MUST BE TYPED WITH ALL REQUESTED INFORMATION COMPLETED.

STREET ADDRESS: 9415 Quail Meadow Drive

LEGAL DESCRIPTION: Subdivision – City of Austin Travis County, Texas

Lot(s) 6 Block D Outlot _____ Division _____

I/We Mr. and Mrs. Velez on behalf of myself/ourselves as authorized agent for

_____ affirm that on _____, _____,

hereby apply for a hearing before the Board of Adjustment for consideration to:

(check appropriate items below)

___ ERECT ___ ATTACH ___ COMPLETE ___ REMODEL ___ MAINTAIN

57% impervious coverage for duplex residential

in a SF-3-NP district. North Austin Civic Association
(zoning district)

NOTE: The Board must determine the existence of, sufficiency of and weight of evidence supporting the findings described below. Therefore, you must complete each of the applicable Findings Statements as part of your application. Failure to do so may result in your application being rejected as incomplete. Please attach any additional support documents.

MAY 14 TH

JUNE 14TH

If you need assistance completing this application (general inquires only) please contact Susan Walker, 974-2202; 505 Barton Springs Road, 2nd Floor (One Texas Center).

CASE#

ROW # _____

CITY OF AUSTIN
APPLICATION TO BOARD OF ADJUSTMENT
GENERAL V ARIANCEIP ARKING VARIANCE

WARNING: Filing of this appeal stops all affected construction activity.

PLEASE: APPLICATION MUST BE TYPED WITH ALL REQUESTED INFORMATION COMPLETED.

STREET ADDRESS:

LEGAL DESCRIPTION: Subdivision- **City of Austin Travis County, Texas**

Lot(s) **6** .Block. **D** Outlot. Division

I1We on behalf of myself *lours* elves as authorized agent for

_____ affinnthmon

hereby apply for a hearing before the Board of Adjustment for consideration to:

(check appropriate items below)

ERECT ATTACH COMPLETE REMODEL (MAINTAIN)

57% Impervious Coverage

in a _____ district.
(zoning district)

NOTE: The Board must determine the existence of, sufficiency of and weight of evidence supporting the findings described below. Therefore, you must complete each of the applicable Findings Statements as part of your application. Failure to do so may result in your application being rejected as incomplete. Please attach any additional support documents.

VARIANCE FINDINGS: I contend that my entitlement to the requested variance is based on the following findings (see page 5 of application for explanation of findings):

REASONABLE USE:

1. The zoning regulations applicable to the property do not allow for a reasonable use because:

Because they need to know the problem that we have inside our property.

HARDSHIP:

2. (a) The hardship for which the variance is requested is unique to the property in that:

It is unique to our property, because it is a medical problem of allergies.

(b) The hardship is not general to the area in which the property is located because:

Because the problem is that the owner of the property suffers of multiple allergies which includes grass and dirt.

AREA CHARACTER:

3. The variance will not alter the character of the area adjacent to the property, will not impair the use of adjacent conforming property, and will not impair the purpose of the regulations of the zoning district in which the property is located because:

Because the variance is a porcion of concrete that we put imside our property and does not affect our neighbors.

PARKING: (Additional criteria for parking variances only.)

Request for a parking variance requires the Board to make additional findings. The Board may grant a variance to a regulation prescribed Section 479 of Chapter 25-6 with respect to the number of off-street parking spaces or loading facilities required if it makes findings of fact that the following additional circumstances also apply:

1. Neither present nor anticipated future traffic volumes generated by the use of the site or the uses of sites in the vicinity reasonable require strict or literal interpretation and enforcement of the specific regulation because:

public streets in a manner as to interfere with the free flow of traffic of the streets because:

3. The granting of this variance will not create a safety hazard or any other condition inconsistent with the objectives of this Ordinance because:

4. The variance will run with the use or uses to which it pertains and shall not run with the site because:

NOTE: The Board cannot grant a variance that would provide the applicant with a special privilege not enjoyed by others similarly situated or potentially similarly situated.

APPLICANT CERTIFICATE – I affirm that my statements contained in the complete application are true and correct to the best of my knowledge and belief.

Signed _____ Mail Address 9415 Quail Meadow Drive

City, State & Zip Austin Texas 78758

Printed Virginia Velez Phone (512)923-8544 Date 5/7/2010

OWNERS CERTIFICATE – I affirm that my statements contained in the complete application are true and correct to the best of my knowledge and belief.

Signed _____ Mail Address 9415 Quail Meadow Drive

City, State & Zip Austin Texas 78758

Printed Virginia Velez Phone (512)923-8544 Date 5/7/2010

N

SUBJECT TRACT

ZONING BOUNDARY

BOARD OF ADJUSTMENTS

ZONING CASE#: C15-2010-0055
ADDRESS: 9415 QUAIL MEADOW DR
GRID: L31
MANAGER: S. WALKER

CITY OF AUSTIN FOUNDED 1839

This map has been produced by the Communications Technology Management Dept. on behalf of the Planning Development Review Dept. for the sole purpose of geographic reference. No warranty is made by the City of Austin regarding specific accuracy or completeness.

MEASUREMENTS

LEFT FRONT ~~1990~~ 1725 SQ. FT.
RIGHT FRONT [illegible] 352 SQ. FT.
LEFT SIDE YARD (NORTH) 1045 SQ. FT.
RIGHT SIDE YARD (SOUTH) 318 SQ. FT.
BACK SIDE YARD 1440 SQ. FT.

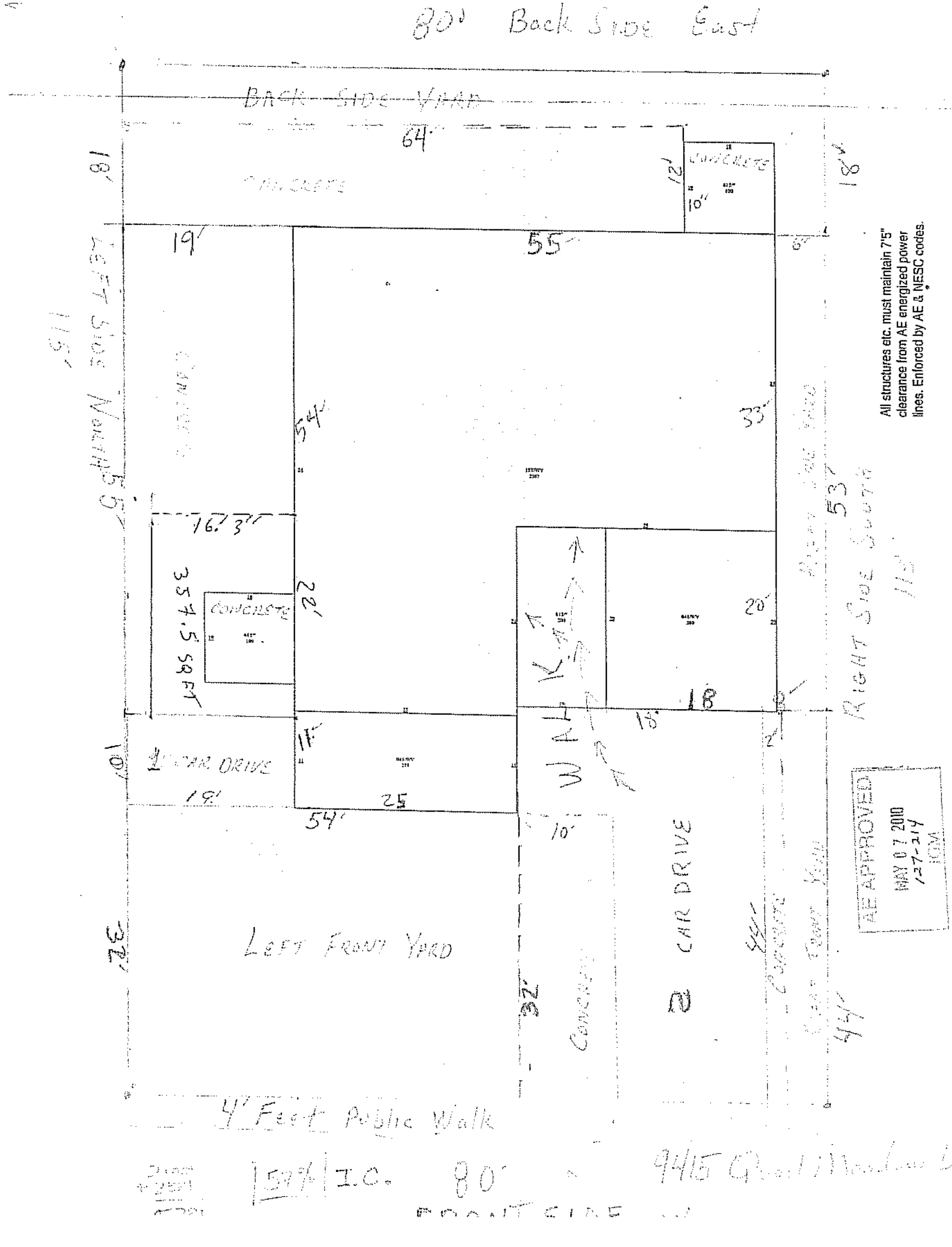
4883 SQ. FT. TOTAL OF COMPLETE YARD

LEFT FRONT CONCRETE 320 SQ. FT.
RIGHT FRONT CONCRETE [illegible] SQ. FT.
LEFT SIDE YARD (NORTH) CONCRETE [illegible] SQ. FT.
RIGHT SIDE YARD (SOUTH) CONCRETE [illegible]
BACK SIDE YARD CONCRETE 368 SQ. FT.

2321 SQ. FT. TOTAL OF CONCRETE

LEFT OF GROUND
[illegible] SQ. FT. LEFT OF GROUND
LEFT OF GROUND
318 SQ. FT. LEFT OF GROUND
514 SQ. FT. LEFT OF GROUND

2562 SQ. FT. TOTAL OF LEFT OF GROUND



THE OTOLOGY GROUP OF TEXAS

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 1/2/2002.
Age: 43.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: New patient consultation.
Referring Physician: Santiago A. Zamora, M.D., 104 Robert T. Martinez JR. St., Austin, Texas 78702-4534.

Chief Complaint: Aural fullness. Headache Frontal Vertigo, Dizziness, Tinnitus, Dysequilibrium, and Imbalance. Post Nasal Drip, nasal congested, itchy, watery eyes, Fatigue, Headaches, Otalgia. Sore Throat. Cough and seasonal Allergies.

Dizziness History: The patient describes acute vertigo spells lasting less than 20 seconds with positional changes. The patient presents with complaints of recurrent, acute spells of dizziness or vertigo, acute onset of dizziness, intermittant spells of vertigo or dizziness, gradual progression of increasing instability, with associated hearing loss and with associated tinnitus. The length of the very first episode of vertigo was days in duration. The problem first began 1.5 years ago. The patient's dizziness is described as intermittant, general disorientation, a spinning sensation, a "foggy"headed sensation, falling to the right, general instability, staggering, lightheadedness, a sensation of weakness"in my legs", feeling off balance and a sensation of dizziness "in my head". The patient describes having having an infection immediately prior to the initial onset of the dizzy symptoms. The episodes are severe and incapacitating and disabling with the patient being bed ridden for days. The last episode of imbalance/vertigo occurred a few days ago. The symptoms are made worse by darkness, placing right ear down, riding in a car, getting out of bed, infections, allergy seasons or allergy attacks, driving at night, stress, increased activity, bending over, looking up, rapid head movements, complicated or active visual patterns/stimuli, exercise and rolling over in bed. The patient has a past history of chancre sores, fever blisters and chicken pox. The patient complains of continuous tinnitus, difficulty hearing in background noise, aural fullness, hearing loss and otalgia associated with their symptoms. The patient has had 0 falls in the past year. The patient also has a history of anxiety. The patient describes no infections as a child. The patient describes being very balanced between attacks or spells. Additional symptom(s) include short term memory loss, difficulty concentrating, an inability to focus on a task, difficulty reading, vomiting, nausea, back pain, stress, recurrent posterior cervical headaches, hearing loss, increased anxiety, visual changes, tinnitis and fatigue. The patient has no complaints of head trauma, recent URI, syncope, otorrhea and fluctuating hearing loss. The patient has never suffered a concussional head injury. The patient has seen 2 doctors prior to this appointment for this problem. CT negative in June 2001.

Imbalance History: The patient describes associated hearing loss, vertigo, tinnitus, fullness of the ears, short term memory loss, difficulty with concentration, anxiety and increase in clumsiness with the onset of their imbalance.
Hearing History: The hearing loss is best described as a muffled sensation to hearing and and worse in the left ear. The patient presents today with complaints of chronic, progressive hearing loss and a recent, acute loss of hearing in the left ear. The patient describes associated tinnitus which is fluctuating, worse in quiet environments and high frequency.
Allergy History: The patient describes a history of seasonal exacerbation of allergies. The major symptoms include post nasal drip, sneezing, nasal congestion, nasal drainage, itchy nose, itchy ears, itchy, watery eyes and frontal sinus pressure. The patient currently complains of trouble sleeping and fatigue.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.
Family Medical History: Patient's father is deceased. The patient's father has a medical history of insulin dependent diabetes mellitus and arteroscelortic cardiovascular disease. The patient's mother has a medical history of oral and diet controlled diabetes. The patient's sibling(s) have a history of diabetes mellitus. Patients sister has been diagnosed with MS.

Allergies: No known drug allergies.

Current Medications: Meclizine. Prednisone 10mg one tablet daily. Penicillin VK 500mg. BID. Cortisporin otic suspension drops BID.

Review of Systems: Active. Generally healthy. Weight loss of 12 #. The patient is a good historian.
ROS Head and Eyes: Patient complains of moderately severe dizzines, it has been present for the last 6 days and Patient's recently developed dizziness. Complains fo watering of the left eye, it is intermittent and it is moderate. Vision can best be described as diminished and patient wears corrective lenses. Patient states that she experienced the sensation of a bright light in her left eye, lasting approximately seven minutes. Patient also states that she had a severe headache following visual problems. Headache was located in the frontal and cervical area.
ROS Ears Nose and Throat: Allergic symptoms: headaches, fullness in throat, nasal congestion, runny nose, itchy, watery eyes and Sneezing.. TINNITUS: Complains of tinnitus on the left side and for the last 1.5 year(s).
ROS Respiratory: Denies any cough, chest pain or shortness of breath.
ROS Cardiovascular: Denies any chest pain, palpitation or lightheadedness.
ROS Gynecological: The patient denies any present or past gynecological problems.
ROS Musculoskeletal:
Complains of right knee.
ROS Extremities: The patient denies any extremities complaints.
ROS Skin: Denies rashes, pruritis, lesions, or bruising.
ROS Gastrointestinal: Patient denies any nausea, vomiting, abdominal pain, dysphagia or any altered bowel movements.
ROS Genitourinary: Denies any genito-urinary complaints.

Examination: The patient was awake, alert and conversant. No acute distress noticed.

Exam Facial: Normal facies, no TMJ tenderness. Eye exam: Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Microscopic exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence.
Exam Nose: The nasal mucosa showed irritation and significantly hyperemia. The exam revealed hypertrophied turbinates.
Exam Oropharynx: The palatine tonsils are with pustules, cryptic with debris and inflammed with marked erythema. Pharynx:erythemetous and pharyngitis.

Tests: The discrimination of the left ear of 100 % at 10 dB above threshold. The discrimination of the right ear at 90 dB or greater was 100 %. The discrimination of the left ear at 90 dB or greater was 80 %. The tympanograms showed a type A pattern in both ears.
Audio/Vestibular Tests: COG testing reveal a right sided, posterior and anterior abnormal pattern.

Impression / Diagnosis: Endolymphatic Hydrops (386.00) viral based, currently with acute exacerbation and left . Endolympahtic hydrops is a condition characterized by a fluid (endolymph) imbalance of the inner ear. Symptoms can include intermittant fullness, intermittant tinnitus, fluctuating hearing and intermittent spells of dizziness/vertigo or imbalance. **Imbalance (781.2) moderate and severe** A sensation of instability which can be constant with intermittant worsening. Secondary symptoms may include cognitive dysfunction, short term memory loss, concentration difficulties, inability to "focus". **Fatigue (780.79) . Allergic Rhinitis (477.80)- Commonly known as "allergies" or "sinus".** . Tonsillitis;.

Medication Prescribed: Valtrex 500 mg po BID. Valium 2 mg #20 Sig: q 6 hours prn severe dizziness.

Plan: The patient will receive 1cc of Celestone and 2cc Depomedrol. Continue Valtrex at current dosage for 12 weeks. Recommend patient receive a testosterone, progesterone, thyroid, estrogen and Somatedin c level within the next few days for possible pituitary dysfunction. Symptoms suggestive of sluggish hypothalamic/pituitary response or possible herpetic involvment of the pituitary axis.
Plan: Recomment subdermal skin testing to airborne antigens. Skin testing in 6weeks.

Follow-up Instructions: Follow-up with doctor in 1 week(s). Audiometry, acoustic reflex and OAE with followup visit. Vestibular Autorotation Test on return visit. Platform posturography with followup visit. Patient instructed on possible complications of treatment and is to phone if concerned over side effects. Patient will be out of work x 1 week.

Physician's Signature: _____ Kendal L. Stewart, M.D. by FNP

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 1/7/2002.
Age: 43.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Vertigo and Imbalance.

History of Present Illness: The patient is currently being treated at The Otology Group of Texas for Endolymphatic Hydrops, Allergic Rhinitis, Chronic Imbalance and a peripheral based vertigo,.
Dizziness History: Denied any further dizzy spells.
Imbalance History: Reports imbalance w/ position changes.
Allergy History: The patient currently complains of no significant allergy symptoms.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.

Allergies: No known drug allergies.

Current Medications: Prednisone 10mg one tablet daily. Valtrex 500 bid. Valium 2 mg prn. Patient has finished her PVK.

ROS Head and Eyes: "Continues w/ a left sided temporal headache and pressure at the left ear. Reports feeling much improved.
ROS Ears Nose and Throat: States feeling tender at the left tonsillar node but denied sore throat , fever, or any allergy symptoms.

Examination: The patient was awake, alert and conversant. No acute distress noticed. Exam Facial: Normal facies, no TMJ tenderness. Eye exam: Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Microscopic exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Neurologic:** Neurological examination reveals that the cranial nerves II to XII are WNL. Cerebellar testing reveals no drift, no dysmetria, no dysdiadochokinesia. Motor system does not reveal any focal weakness. Strength is good in all muscle groups. Gait is narrow based with good pace. **Exam Skin:** Normal turgor and elasticity; no significant skin lesions. **Exam Respiratory:** Chest symmetrical, normal, breath sounds equal, bilateral symmetrical, no rales or rhonchi and no dullness to percussion.

Exam Nose: The nasal mucosa showed irritation and significantly hyperemia. The exam revealed hypertrophied turbinates.
Exam Oropharynx: The palatine tonsils are with pustules on the left side. No visible erythema.
Exam Neck: Movable 2mm x2 mm node that is tender to palpation.

Tests: The discrimination scores are improving and in the left ear. The OAE reveals a hyperacusic pattern with hydroptic low frequency drop bilaterally. The discrimination of the right ear at 90 dB or greater was 100 %. The discrimination of the left ear at 90 dB or greater was 96 %. The acoustic reflexes were normal in both ears. The otoacoustic emissions revealed decreased SPL levels in mid frequencies, low frequencies and both ears. OAEs show signigicant improvement in recovery of response since the last visit.

Impression / Diagnosis: Endolymphatic Hydrops (386.00) viral based, currently with acute exacerbation and left sided - improving. Endolympahtic hydrops is a condition characterized by a fluid (endolymph) imbalance of the inner ear. Symptoms can include intermittant fullness, intermittant tinnitus, fluctuating hearing and intermittent spells of dizziness/vertigo or imbalance. **Labryinthitis- improving . Imbalance (781.2) moderate and severe** A sensation of instability which can be constant with intermittant worsening. Secondary symptoms may include cognitive dysfunction, short term memory loss, concentration difficulties, inability to "focus". **Fatigue (780.79) . Allergic Rhinitis (477.80)- Commonly known as "allergies" or "sinus". . Tonsillitis-not recovered.**

Medication Prescribed: Stop Prednisone and use Valium only prn "severe" dizzy symptoms. Continue Valtrex at 500 mg bid.

Medication Prescribed:
Z-Pak #1 as directed for infection.

Plan: Continue Valtrex at current dosage for 12 weeks. Recommend patient receive a Somatedin c level within the next few days for possible pituitary dysfunction. Symptoms suggestive of sluggish hypothalamic/pituitary response or possible herpetic involvment of the pituitary axis. Will discuss allergy testing at the next visit.

Follow-up Instructions: Follow-up with doctor in 10 day(s). Audiometry, acoustic reflex and OAE with followup visit. Vestibular Autorotation Test on return visit. Platform posturography with followup visit. Patient instructed on possible complications of treatment and is to phone if concerned over side effects. Have provided patient w/ an excuse to refrain from work until 1/14/02. She will call if not better.

Physician's/ NP Signature: _____ Beljssa Zamora, FNP
As supervised by Kendal L. Stewart, M.D.

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(512) 338-0863 Fax

Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 1/16/2002.
Age: 43.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Patient states that she resumed work on Monday and became very shakey and was sent home. Patient continues to have intermittent floating sensation when looking up.

History of Present Illness: The patient is currently being treated at The Otology Group of Texas for Endolymphatic Hydrops, Allergic Rhinitis, Chronic Imbalance and a peripheral based vertigo,.
Dizziness History: The patient's dizziness is described as general disorientation, a "foggy"headed sensation, lightheadedness and a sensation of dizziness "in my head". The problem first began 3 days ago. The episodes are mild, but annoying.
Imbalance History: The patient describes minimal improvement in balance and a fluctuation of symptoms.
Hearing History: The hearing loss is best described as a muffled sensation to hearing.
Allergy History: The patient currently complains of no significant allergy symptoms.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.

Allergies: No known drug allergies.

Current Medications: Valtrex 500 bid. Valium 2 mg prn.

Review of Systems: Active. Generally healthy. Weight loss of 12 #. The patient is a good historian.
ROS Head and Eyes: Pressure with pain in the left eye.
ROS Respiratory: Denies any cough, chest pain or shortness of breath.
ROS Cardiovascular: Denies any chest pain, palpitation or lightheadedness.
ROS Gynecological: The patient denies any present or past gynecological problems.
ROS Musculoskeletal: The patient denies any musculoskeletal complaints.
ROS Extremities: The patient denies any extremities complaints.
ROS Gastrointestinal: Patient denies any nausea, vomiting, abdominal pain, dysphagia or any altered bowel movements.
ROS Genitourinary: Denies any genito-urinary complaints.

Examination: The patient was awake, alert and conversant. No acute distress noticed. Exam Facial: Normal facies, no TMJ tenderness. Eye exam: Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Microscopic exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly.

Tests: Air 125 HZ: AS: 20 dB and AD: 20 dB. The patient received no testing today. Air 250 Hz: AS: 20 dB and AD: 20 dB. Air 500 Hz: AD: 15 dB and AS: 10 dB. Air 1000 Hz: AS: 15 dB and AD: 10 dB. Air 2000 Hz: AS: 15 dB and AD: 10 dB. Air 4000 Hz: AS: 10 dB and AD: 15 dB. Air 8000 Hz: AD: 10 dB and AS: 5 dB. The audiogram revealed improving pure tone freqencies in mid tones, the low tones and Left ear.. The discrimination in the right ear was 100% at MCL. The discrimination of the left ear was 100 % at MCL. The discrimination of the right ear at 90 dB or greater was 100 %. The discrimination of the left ear at 90 dB or greater was 92 %. The tympanograms showed a type A pattern in both ears. The otoacoustic emissions revealed decreased SPL levels in low frequencies and both ears.
Audio/Vestibular Tests: The platform posturography shows an abnormal sway pattern in all conditions with a SOT score of 52. Center of gravity was moderately scattered. COG testing reveal a posterior and anterior abnormal pattern.

Impression / Diagnosis: Endolymphatic Hydrops (386.00) viral based, currently with acute exacerbation and left . Endolympahtic hydrops is a condition characterized by a fluid (endolymph) imbalance of the inner ear. Symptoms can include intermittant fullness, intermittant tinnitus, fluctuating hearing and intermittent spells of dizziness/vertigo or imbalance. **Imbalance (781.2) moderate and severe** A sensation of instability which can be constant with intermittant worsening. Secondary symptoms may include cognitive dysfunction, short term memory loss, concentration difficulties, inability to "focus". **Fatigue (780.79) . Allergic Rhinitis (477.80)- Commonly known as "allergies" or "sinus".** . Tonsillitis- recovered.

Medication Prescribed: Continue same meds as previously prescribed.

Follow-up Instructions: Follow-up with doctor in 4 week(s). Patient instructed on possible complications of treatment and is to phone if concerned over side effects. Patient will be returning to work on 1/28/02.

Physician's/NP Signature: _____ Belissa Zamora, FNP
As supervised by Kendal L. Stewart, M.D.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 1/17/2002.
Age: 43.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Plan: Patient to Receive and otolith repositioning by the physical therapist and followup with therapist in 3 days.. Dix Hall pike during the office visit today indicates right sided Canalithiasis. Treated succesfully w/ an Otolith. Patient escorted home w/ a family member.

Physician's/NP Signature: _____ Belissa Zamora, fNP
As supervised by Kendal L. Stewart, M.D.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 2/27/2002.
Age: 44.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Continued minimal intermittent episode of dizziness with movement.

History of Present Illness: The patient is currently being treated at The Otology Group of Texas for Endolymphatic Hydrops, Allergic Rhinitis, Chronic Imbalance and a peripheral based vertigo,. Patient feels better but not 100%. Describes an intermittent residual imbalance.
Imbalance History: The patient describes significant improvement in balance.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.

Allergies: No known drug allergies.

Current Medications: No current medications.

Review of Systems: Generally healthy. Active. The patient is a good historian. The patient reports a stable weight pattern.
ROS Head and Eyes: Denies vision changes, light sensitivity, blurred vision, or double vision.
ROS Ear, Nose and Throat: The patient denies any ear, nose or throat symptoms.
ROS Respiratory: Patient denies any respiratory complaints, such as cough, shortness of breath, chest pain, wheezing, hemoptysis, etc.
ROS Cardiovascular: The patient has no history of cardiovascular symptoms, such as chest pain, palpitation, lightheadedness, syncope, etc.
ROS Gastrointestinal: Patient denies any gastrointestinal symptoms, such as anorexia, weight loss, dysphagia, nausea, vomiting, abdominal pain, abdominal distention, altered bowel movements, diarrhea, constipation, rectal bleeding, hematochesia, e.
ROS Genitourinary: Patient denies any genito-urinary complaints, such as hematuria, dysuria, frequency, urgency, hesitancy, nocturia, incontinence, etc.
ROS Gynecological: Denies any gynecological complaints, such as vaginal bleeding, discharge, pain, etc.
ROS Musculoskeletal: The patient denies any past or present problems related to the musculoskeletal system.
ROS Extremities: The patient denies any extremities complaints.
ROS Skin: Denies rashes, pruritis, lesions, bruising.

Examination: The patient was awake, alert and conversant. No acute distress noticed. Exam Facial: Normal facies, no TMJ tenderness. Eye exam: Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Microscopic exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Skin:** Normal turgor and elasticity; no significant skin lesions. **Exam Respiratory:** Chest symmetrical, normal, breath sounds equal, bilateral symmetrical, no rales or rhonchi and no dullness to percussion.

Tests: Air 125 HZ: AS: 15 dB and AD: 15 dB. Air 250 Hz: AS: 20 dB and AD: 10 dB. Air 500 Hz: AD: 15 dB and AS: 15 dB. Air 1000 Hz: AS: 15 dB and AD: 10 dB. Air 2000 Hz: AS: 15 dB and AD: 15 dB. Air 4000 Hz: AS: 10 dB and AD: 15 dB. Air 8000 Hz: AD: 10 dB and AS: 15 dB. The discrimination of the right ear at 90 dB or greater was 100 %. The discrimination of the left ear at 90 dB or greater was 100 %. The tympanograms showed a type A pattern in both ears. The otoacoustic emissions revealed decreased SPL levels in high frequencies and the right ear. **Audio/Vestibular Tests:** The platform posturography showed an abnormal vestibular sway pattern in conditions 5 and 6 with a SOT score of 80. COG testing reveal a right sided and anterior abnormal pattern. The horizontal VAT exam revealed high abnormal gains. **Laboratory Tests:** Somatomedin C 110. date 01/23/02.

Impression / Diagnosis: #1 Endolymphatic Hydrops (386.00) viral based, currently with acute exacerbation and left --resolved. Endolympahtic hydrops is a condition characterized by a fluid (endolymph) imbalance of the inner ear. Symptoms can include intermittant fullness, intermittant tinnitus, fluctuating hearing and intermittent spells of dizziness/vertigo or imbalance. #2 Imbalance (781.2) moderate and severe, with Benign Positional Vertigo, treated and patient continues w/ a residual VOR abnormality requiring Vestibular Therapy. A sensation of instability which can be constant with intermittant worsening. Secondary symptoms may include cognitive dysfunction, short term memory loss, concentration difficulties, inability to "focus". #3Fatigue (780.79), unresolved and addressed with the replacement of HGH. #4 Allergic Rhinitis (477.80)- Commonly known as "allergies" or "sinus, if patient's dizziness recurs we will address allergy testing. #5 Tonsillitis- recovered.

Plan: Instructed patient on the use of the antiviral for any future episodes of dizziness. She verbalized understanding to use Valtrex prn and to call us if her dizziness does recur. Discussed the value of growth hormone replacement in the repair of tissues and recommended she pursue using Recom Maximum Strength Spray at 12 sprays per day for the duration of 3 months. I have referred her to receive Vestibular Rehabilitation at Elite Physical Therapy.

Follow-up Instructions: Follow-up with doctor in 2 month(s). Audiometry, acoustic reflex and OAE with followup visit. Vestibular Autorotation Test on return visit. Platform posturography with followup visit. Patient instructed on possible complications of treatment and is to phone if concerned over side effects.

Physician's/NP Signature: _____ Belissa Zamora, FNP
As supervised by Kendal L. Stewart, M.D.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 3/4/2002.
Age: 44.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Dizziness.

History of Present Illness: The patient is currently being treated at The Otology Group of Texas for Endolymphatic Hydrops, Allergic Rhinitis, Chronic Imbalance and a peripheral based vertigo. Patient presents w/ a new onset of severe dizziness yesterday after awakening. **Dizziness History:** The patient is currently taking no medications for their condition. The patient describes an acute exacerbation of their symptoms of vertigo spells severity and imbalance since they were last seen.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.

Allergies: No known drug allergies.

Current Medications: No current medications.

Review of Systems: Generally healthy. Active. The patient is a good historian.
ROS Ears Nose and Throat: As per HPI.

Examination: The patient was awake, alert and conversant. No acute distress noticed. Exam Facial: Normal facies, no TMJ tenderness. Eye exam: Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Microscopic exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly. **Exam Skin:** Normal turgor and elasticity; no significant skin lesions. **Exam Respiratory:** Chest symmetrical, normal, breath sounds equal, bilateral symmetrical, no rales or rhonchi and no dullness to percussion.

Tests: The patient received no testing today.

Plan: The patient will receive 1cc of Celestone and 2cc Depomedrol. Use Valtrex 500 mg bid x 1-2 weeks prn dizzy spells. Will have the patient call me in 3 days for a report on her dizziness. If patient's symptoms continue to recur w/ position changes, will have her re-evaluated by the PT for BPPV.

Follow-up Instructions: Keep appointment as scheduled.

Physician'/NP Signature: _____ Belissa Zamora, FNP
As supervised by Kendal L. Stewart, M.D.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 3/12/2002.
Age: 44.

Attending Physician: Kendal L. Stewart, M.D.

Chief Complaint: Aural fullness and Imbalance. Left ear and left facial pain.

History of Present Illness: The patient is currently being treated at The Otology Group of Texas for Endolymphatic Hydrops, Allergic Rhinitis, Chronic Imbalance and a peripheral based vertigo.
Ear History: The patient describes no otalgia. The patient has no otorrhea.
Dizziness History: The patient describes no to very little change in their vertigo severity and vertigo duration since they were last seen.
Imbalance History: The patient describes worsening distractability, trouble sleeping, worsening of tinnitus, worsening of their imbalance, fatigue and a worsening in the cognitive ability.
Allergy History: The patient currently complains of no significant allergy symptoms.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.

Allergies: No known drug allergies.

Current Medications: Valtrex 500 bid. Today is last dose on Z-Pak.

Review of Systems: Generally healthy. Inactive. The patient is a good historian. Feels poorly. The patient reports a stable weight pattern. The patient complains of feeling tired all the time.
ROS Respiratory: Patient denies any respiratory complaints, such as cough, shortness of breath, chest pain, wheezing, hemoptysis, etc.
ROS Cardiovascular: The patient has no history of cardiovascular symptoms, such as chest pain, palpitation, lightheadedness, syncope, etc.
ROS Gastrointestinal: Patient denies any gastrointestinal symptoms, such as anorexia, weight loss, dysphagia, nausea, vomiting, abdominal pain, abdominal distention, altered bowel movements, diarrhea, constipation, rectal bleeding, hematochesia, e.
ROS Genitourinary: Patient denies any genito-urinary complaints, such as hematuria, dysuria, frequency, urgency, hesitancy, nocturia, incontinence, etc.
ROS Gynecological: Denies any gynecological complaints, such as vaginal bleeding, discharge, pain, etc.

ROS Musculoskeletal: The patient denies any past or present problems related to the musculoskeletal system.
ROS Extremities: The patient denies any extremities complaints.
ROS Skin: Denies rashes, pruritis, lesions, bruising.
ROS Head and Eyes: Pressure with pain in the left eye.
ROS Ears Nose and Throat: Pain in left ear and left side of face.

Examination: The patient was awake, alert and conversant. No acute distress noticed. Exam Facial: Normal facies, no TMJ tenderness. Eye exam: Normal vision; EOM intact; no nystagmus. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly. Rhomberg reveals severe anterior-posterior swaying and lateral sway with no fall. Dix Hallpike manuever revealed rotatory nystagmus and with right ear down.
Exam Ear: Microscopic exam of the ears was performed bilaterallty. Exam revealed normal pinnae #S#. The external auditory canals are normal without evidence of erythema, cerumen or stenosis. Exam revealed normal tympanic membranes bilaterally. The middle ear spaces appear normal and free of effusion.

Tests: Air 125 HZ: AS: 10 dB and AD: 15 dB. Air 250 Hz: AS: 15 dB and AD: 15 dB. Air 500 Hz: AD: 15 dB and AS: 15 dB. Air 1000 Hz: AS: 15 dB and AD: 10 dB. Air 2000 Hz: AS: 10 dB and AD: 10 dB. Air 4000 Hz: AS: 10 dB and AD: 10 dB. Air 8000 Hz: AD: 5 dB and AS: 15 dB. There were elevated reflex threshlolds present in both ears. The discrimination of the right ear at 90 dB or greater was 100 %. The discrimination of the left ear at 90 dB or greater was 100 %. The tympanograms showed a type A pattern in both ears.
Audio/Vestibular Tests: The platform posturography showed an abnormal vestibular sway pattern in conditions 5 and 6 with a SOT score of 53. COG testing reveal a right sided and anterior abnormal pattern. The vertical plane VAT revealed high normal gains. The patient underwent an ImPACT neurocognitive test which revealed a Word Memory Score of 93%, a Memory Composite Score of 93% and a Totoal Symptom Score of 93. The horizontal VAT exam revealed low normal gains.
Procedure: The patient had otolith Repositioning procedure done in the office today per protocol.

Impression / Diagnosis: #1 Endolymphatic Hydrops (386.00) viral based, currently with acute exacerbation and left --resolved. Endolympahtic hydrops is a condition characterized by a fluid (endolymph) imbalance of the inner ear. Symptoms can include intermittant fullness, intermittant tinnitus, fluctuating hearing and intermittent spells of dizziness/vertigo or imbalance. #2 Imbalance (781.2) moderate and severe, with Benign Positional Vertigo, treated and patient continues w/ a residual VOR abnormality requiring Vestibular Therapy. A sensation of instability which can be constant with intermittant worsening. Secondary symptoms may include cognitive dysfunction, short term memory loss, concentration difficulties, inability to "focus". #3Fatigue (780.79), unresolved and addressed with the replacement of HGH. #4 Allergic Rhinitis (477.80)- Commonly known as "allergies" or "sinus, if patient's dizziness recurs we will address allergy testing. #5 Tonsillitis- recovered.

Medication Prescribed: Continue Valtrex 500 mg bid. Continue HGH supplement.

Plan: The patient will receive Depo-Medrol 80mg/cc and Celestone Soluspan 6mg./cc I.M... Patient to vestibular rehabilitation evaluation in 1 weeks. scheduled for PT eval. On 3/14/02.
Plan: Continue current immunotherapy.

Follow-up Instructions: Follow-up with doctor in 1 day(s). Will call patient with diagnostic results. Audiometry, acoustic reflex and OAE with followup visit. Patient instructed on possible complications of treatment and is to phone if concerned over side effects.

Physician's Signature: _____ Kendal L. Stewart, M.D.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 3/18/2002.
Age: 44.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.
Referring Physician: Santiago A. Zamora, M.D., 104 Robert T. Martinez JR. St., Austin, Texas 78702-4534.

Chief Complaint: Aural fullness and Dizziness. One week follow up after Otolith Repositioning.

History of Present Illness: The patient is currently being treated at The Otology Group of Texas for Endolymphatic Hydrops, Allergic Rhinitis, Chronic Imbalance and a peripheral based vertigo. The patient is stable and has had no significant fluctuations in symptoms. The patient describes slow, but steady improvement.
Dizziness History: The patient is currently taking Valtrex 500 BID for their condition. The patient describes an improvement in their dizzy symptoms since they were last seen. The patient describes an acute exacerbation of their symptoms of concentration, headaches, short term memory and fatigue since they were last seen. The patient describes no to very little change in their imbalance and sleep patterns since they were last seen. Patient states she has been feeling "shaky".
Processing History: The patient has associated symptoms including difficulty focusing, inattentiveness, trouble with concentrtion and short memory.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.

Allergies: No known drug allergies.

Current Medications: Valtrex 500 bid.

Review of Systems: Generally healthy. Inactive. The patient is a good historian. The patient reports a stable weight pattern. The patient complains of feeling tired all the time. No significant changes since last Review of Systems.

Examination: The patient was awake, alert and conversant. No acute distress noticed. Exam Facial: Normal facies, no TMJ tenderness. Eye exam: Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Microscopic exam of the ears revealed normal

external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly. **Exam Skin:** Normal turgor and elasticity; no significant skin lesions. **Exam Respiratory:** Chest symmetrical, normal, breath sounds equal, bilateral symmetrical, no rales or rhonchi and no dullness to percussion. **Exam Nose:** The nasal mucosa showed irritation and significantly hyperemia. The exam revealed hypertrophied turbinates.

Tests: The patient received no testing today.

Impression / Diagnosis: #1 Endolymphatic Hydrops (386.00) viral based, currently with acute exacerbation and left --resolved. Endolympahtic hydrops is a condition characterized by a fluid (endolymph) imbalance of the inner ear. Symptoms can include intermittant fullness, intermittant tinnitus, fluctuating hearing and intermittent spells of dizziness/vertigo or imbalance. #2 Imbalance (781.2) moderate and severe, with Benign Positional Vertigo, treated and patient continues w/ a residual VOR abnormality requiring Vestibular Therapy. A sensation of instability which can be constant with intermittant worsening. Secondary symptoms may include cognitive dysfunction, short term memory loss, concentration difficulties, inability to "focus". #3Fatigue (780.79), unresolved and addressed with the replacement of HGH. #4 Allergic Rhinitis (477.80)- Commonly known as "allergies" or "sinus, if patient's dizziness recurs we will address allergy testing. Will address this with antihistamines at this time.

Medication Prescribed: Continue same meds as previously prescribed. Add Zyrtec 10 mg po qd to her daily medications (10 samples provided) Rx written for #30 R3.

Plan: Patient to continue vestibular rehabilitation visits.

Follow-up Instructions: Follow-up with doctor in 2 week(s). Audiometry, acoustic reflex and OAE with followup visit. Vestibular Autorotation Test on return visit. Platform posturography with followup visit. Patient instructed on possible complications of treatment and is to phone if concerned over side effects.

Physician's/NP Signature: _____ Belissa Zamora, FNP
As supervised by Kendal L. Stewart, M.D.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 4/3/2002.
Age: 44.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Aural fullness and Dizziness.

Dizziness History: The patient is currently taking Valtrex 500 BID for their condition. The patient describes an improvement in their short term memory, cognitive ability, fatigue and headaches since they were last seen. The patient describes an acute exacerbation of their symptoms of headache since they were last seen.
Allergy History: The patient is currently taking Zyrtec for their allergies. The patient currently complains of recurrent sinus headaches. The patient is currently taking for their sinus and allergy symptoms.
Processing History: The patient has associated symptoms including difficulty focusing, inattentiveness, trouble with concentrtion and short memory. Sleep problems. Participating w/ Vestibular Rehab. Last Otolith was last week.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.

Allergies: No known drug allergies.

Current Medications: Valtrex 500 bid. Zyrtec 10 qd . HGH Max 9/day.

Review of Systems: Generally healthy. Active. The patient is a good historian. The patient reports a stable weight pattern.
ROS Cardiovascular: The patient has no history of cardiovascular symptoms, such as chest pain, palpitation, lightheadedness, syncope, etc.
ROS Gastrointestinal: Patient denies any gastrointestinal symptoms, such as anorexia, weight loss, dysphagia, nausea, vomiting, abdominal pain, abdominal distention, altered bowel movements, diarrhea, constipation, rectal bleeding, hematochesia, e.
ROS Musculoskeletal: The patient denies any past or present problems related to the musculoskeletal system.
ROS Extremities: The patient denies any extremities complaints.
ROS Skin: Denies rashes, pruritis, lesions, bruising.

ROS Head and Eyes: Patient has following symptoms associated with the headache : Headaches associated with allergy symptoms..
ROS Ears Nose and Throat: As per HPI.

Examination: The patient was awake, alert and conversant. No acute distress noticed. Exam Facial: Normal facies, no TMJ tenderness. Eye exam: Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Microscopic exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly. **Exam Skin:** Normal turgor and elasticity; no significant skin lesions. **Exam Respiratory:** Chest symmetrical, normal, breath sounds equal, bilateral symmetrical, no rales or rhonchi and no dullness to percussion. **Exam Nose:** The nasal mucosa showed irritation and significantly hyperemia. The exam revealed hypertrophied turbinates.

Tests: There were elevated reflex threshlolds present in both ears. Audiogram unchanged since the last visit. The discrimination in the right ear was 100% at MCL. The discrimination of the left ear was 100 % at MCL. The discrimination of the right ear at 90 dB or greater was 96 %. The discrimination of the left ear at 90 dB or greater was 100 %. The tympanograms showed a type A pattern in both ears. The otocoustic emmissions revealed normal SPL levels bilaterally. OAEs show signigicant improvement in recovery of response since the last visit.
Audio/Vestibular Tests: COG testing reveal a posterior, anterior and stable abnormal pattern. The vertical plane VAT revealed phase abnormality, high normal gains and improving. The horizontal VAT exam revealed normal gains.
Laboratory Tests: Somatomedin C 110. date 01/23/02.

Impression / Diagnosis: #1 Endolymphatic Hydrops (386.00) viral based, currently with acute exacerbation and left --resolved. Endolympahtic hydrops is a condition characterized by a fluid (endolymph) imbalance of the inner ear. Symptoms can include intermittant fullness, intermittant tinnitus, fluctuating hearing and intermittent spells of dizziness/vertigo or imbalance. #2 Imbalance (781.2) moderate and severe, with Benign Positional Vertigo, treated and patient continues w/ a residual VOR abnormality requiring Vestibular Therapy. A sensation of instability which can be constant with intermittant worsening. Secondary symptoms may include cognitive dysfunction, short term memory loss, concentration difficulties, inability to "focus". #3Fatigue (780.79), unresolved and addressed with the replacement of HGH. #4 Allergic Rhinitis (477.80)- Commonly known as "allergies" or "sinus, if patient's dizziness recurs we will address allergy testing. Will address this with antihistamines at this time.

Plan: Patient to continue vestibular rehabilitation visits. Plan to pursue Vestibular Rehab for the chronic imbalance x another month. We will keep her out of work x one more month and reevaluate on May 6 ,2002. Decrease the HGH to 6 sprays/day. Continue the Valtrex at 500 bid. Hold Zyrtec as I believe it is drying the sinuses too much. Use Guaifenesin bid.
Plan: Recomment subdermal skin testing to airborne antigens.

Follow-up Instructions: Patient instructed on possible complications of treatment and is to phone if concerned over side effects. The patient will continue on the Orange protocol and will receive Audiometry, acoustic reflex, OAE, CTSIB, VAT and ImPACT on their return visit in 4 weeks.

Physician's Signature: Kendal L. Stewart, M.D.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 5/6/2002.
Age: 44.

Referring Physician: Santiago A. Zamora, M.D.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Aural fullness and Dizziness.

History of Present Illness: The patient is currently being treated at The Otology Group of Texas for Endolymphatic Hydrops, Allergic Rhinitis, Chronic Imbalance and a peripheral based vertigo. The patient is stable and has had no significant fluctuations in symptoms. The patient describes slow, but steady improvement.
Dizziness History: The patient is currently taking Valtrex 500 BID for their condition. The patient describes an improvement in their short term memory, cognitive ability, fatigue and headaches since they were last seen. The patient describes an acute exacerbation of their symptoms of headache since they were last seen. She reports not being able to sleep in a recumbent position. She continues to sense a significant vertigo that lasts seconds with a recumbent position and if she looks down. Her symptoms of positional vertigo are now occurring daily. She has been finished with vestibular therapy x 2 weeks. Has not had an Otolith for several weeks (last performed at Health South by the PT).

Imbalance History: The patient describes worsening distractability, trouble sleeping, worsening of tinnitus, worsening of their imbalance, fatigue and a worsening in the cognitive ability.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.

Allergies: No known drug allergies.

Current Medications: Valtrex 500 bid. Zyrtec 10 qd . HGH Max 9/day.Duratuss.

Review of Systems: Generally healthy. Active. Inactive. The patient is a good historian. The patient reports a stable weight pattern.
ROS Respiratory: Patient denies any respiratory complaints, such as cough, shortness of breath, chest pain, wheezing, hemoptysis, etc.

ROS Cardiovascular: The patient has no history of cardiovascular symptoms, such as chest pain, palpitation, lightheadedness, syncope, etc.
ROS Gastrointestinal: Patient denies any gastrointestinal symptoms, such as anorexia, weight loss, dysphagia, nausea, vomiting, abdominal pain, abdominal distention, altered bowel movements, diarrhea, constipation, rectal bleeding, hematochesia, e.
ROS Genitourinary: Patient denies any genito-urinary complaints, such as hematuria, dysuria, frequency, urgency, hesitancy, nocturia, incontinence, etc.
ROS Musculoskeletal: The patient denies any past or present problems related to the musculoskeletal system.
ROS Extremities: The patient denies any extremities complaints.
ROS Skin: Denies rashes, pruritis, lesions, bruising.
ROS Ears Nose and Throat: As per HPI.

Examination: The patient was awake, alert and conversant. No acute distress noticed. Exam Facial: Normal facies, no TMJ tenderness. Eye exam: Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Microscopic exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly. **Rhomberg reveals minor anterior- posterior sway.** Tandem rhomberg reveals lateral sway with a fall to the left after 2 seconds . Exam Skin: **Normal turgor and elasticity; no significant skin lesions.** Exam Respiratory: Chest symmetrical, normal, breath sounds equal, bilateral symmetrical, no rales or rhonchi and no dullness to percussion.

Tests: Air 125 HZ: AS: 20 dB and AD: 15 dB. Air 250 Hz: AS: 20 dB and AD: 10 dB. Air 500 Hz: AD: 15 dB and AS: 15 dB. Air 1000 Hz: AS: 15 dB and AD: 10 dB. Air 2000 Hz: AS: 15 dB and AD: 15 dB. Air 4000 Hz: AS: 10 dB and AD: 15 dB. Air 8000 Hz: AD: 20 dB and AS: 15 dB. There were elevated reflex threshlolds present in both ears. The discrimination in the right ear was 100% at MCL. The discrimination of the left ear was 100 % at MCL. The discrimination of the right ear at 90 dB or greater was 100 %. The discrimination of the left ear at 90 dB or greater was 96 %. The tympanograms showed a type A pattern in both ears. The otoacoustic emissions revealed decreased SPL levels in mid frequencies and both ears.
Audio/Vestibular Tests: The platform posturography showed an abnormal vestibular sway pattern in conditions 5 and 6 with a SOT score of 65. COG testing reveal a right sided and posterior abnormal pattern. The vertical plane VAT revealed low normal gains. The patient underwent an ImPACT neurocognitive test which revealed a Word Memory Score of 89%, a Memory Composite Score of 76% and a Totoal Symptom Score of 37. The horizontal VAT exam revealed high normal gains.
Laboratory Tests: Somatomedin C 110. date 01/23/02.

Impression / Diagnosis: #1 Endolymphatic Hydrops (386.00) viral based, currently with acute exacerbation and left --resolved. Endolympahtic hydrops is a condition characterized by a fluid (endolymph) imbalance of the inner ear. Symptoms can include intermittant fullness, intermittant tinnitus, fluctuating hearing and intermittent spells of dizziness/vertigo or imbalance. **#2** Imbalance (781.2) moderate and severe, with **Benign Positional Vertigo**, treated and patient continues w/ a residual VOR abnormality requiring Vestibular Therapy and reports symptomatic

BPPV when in a recumbent position. A sensation of instability which can be constant with intermittant worsening. Secondary symptoms may include cognitive dysfunction, short term memory loss, concentration difficulties, inability to "focus". **#3Fatigue** (780.79), unresolved and addressed with the replacement of HGH. **#4 Allergic Rhinitis** (477.80)- Commonly known as "allergies" or "sinus, if patient's dizziness recurs we will address allergy testing. Will address this with antihistamines at this time.

Medication Prescribed: Continue same meds as previously prescribed.

Plan: The patient will receive 1cc of Celestone and 2cc Depomedrol. Patient to Receive and otolith repositioning by the physical therapist and followup with therapist in 3 days. vestibular rehabilitation evaluation in 1 weeks. Due to patient's persistent BPPV we will send her back to PT for an Otolith and further vestibular rehab. She continues to be out of work due to her limitations.

Follow-up Instructions: Patient instructed on possible complications of treatment and is to phone if concerned over side effects. The patient will continue in the Blue Protocol and will receive Audiometry, OAE, Acoustic Reflex testing, and posturography on their return visit in 3 weeks.

Physician's/NP Signature: _____ Belissa Zamora, FNP
As supervised by Kendal L. Stewart, M.D.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 5/30/2002.
Age: 44.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Continued aural fullness and Dizziness. No Improvement.

History of Present Illness: The patient is currently being treated at The Otology Group of Texas for Endolymphatic Hydrops, Allergic Rhinitis, Chronic Imbalance and a peripheral based vertigo. The patient is stable and has had no significant fluctuations in symptoms. The patient describes slow, but steady improvement.
Ear History: The patient describes no otalgia. The patient has no otorrhea.
Dizziness History: The patient describes no to very little change in their imbalance, vertigo severity, tinnitus and fullness since they were last seen.
Imbalance History: The patient describes significant improvement in balance. Pt. Has completed physical therapy, and is currently on home exercise program. She has had one episode of vertigo, and was able to resolve this using the techniques she learned at PT. She has some anxiety regarding her BPPV, attention deficits and memory deficits, but believes there is slow, steady improvement.
Allergy History: The patient currently complains of lightheaded and ear fullness.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.

Allergies: No known drug allergies.

Current Medications: Valtrex 500 bid. Zyrtec 10 qd . HGH Max 9/day.Duratuss.

Review of Systems: Generally healthy. Active. The patient is a good historian. The patient reports a stable weight pattern.
ROS Ear, Nose and Throat: The patient denies any ear, nose or throat symptoms.
ROS Respiratory: Patient denies any respiratory complaints, such as cough, shortness of breath, chest pain, wheezing, hemoptysis, etc.
ROS Cardiovascular: The patient has no history of cardiovascular symptoms, such as chest pain, palpitation, lightheadedness, syncope, etc.

ROS Gastrointestinal: Patient denies any gastrointestinal symptoms, such as anorexia, weight loss, dysphagia, nausea, vomiting, abdominal pain, abdominal distention, altered bowel movements, diarrhea, constipation, rectal bleeding, hematochesia, e.
ROS Gynecological: Denies any gynecological complaints, such as vaginal bleeding, discharge, pain, etc.
ROS Musculoskeletal: The patient denies any past or present problems related to the musculoskeletal system.
ROS Extremities: The patient denies any extremities complaints.
ROS Skin: Denies rashes, pruritis, lesions, bruising.
ROS Head and Eyes: Patient has following symptoms associated with the headache : Headaches associated with allergy symptoms.. Patient complains of moderately severe dizzines and overall it is getting better.
ROS Genitourinary: Patient has been treated for a bladder since her last visit. Treated for five days with an antibiotic.

Examination: The patient was awake, alert and conversant. No acute distress noticed. Exam Facial: Normal facies, no TMJ tenderness. Eye exam: Normal vision; EOM intact; no nystagmus. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly. Rhomberg reveals severe anterior-posterior swaying.
Exam Ear: Microscopic exam of the ears was performed bilaterallty. Exam revealed normal pinnae #S#. The external auditory canals are normal without evidence of erythema, cerumen or stenosis. Exam revealed normal tympanic membranes bilaterally. The middle ear spaces appear normal and free of effusion.
Exam Nose: The nasal mucosa showed irritation and significantly hyperemia. The exam revealed hypertrophied turbinates.

Tests: Air 125 HZ: AS: 20 dB and AD: 15 dB. Air 250 Hz: AS: 25 dB and AD: 15 dB. Air 500 Hz: AD: 15 dB and AS: 20 dB. Air 1000 Hz: AS: 15 dB and AD: 10 dB. Air 2000 Hz: AS: 15 dB and AD: 20 dB. Air 4000 Hz: AS: 5 dB and AD: 5 dB. Air 8000 Hz: AD: 10 dB and AS: 15 dB. There were elevated reflex threshlolds present in both ears. The audiogram revealed worsening pure tones in the low frequencies and left ear. The discrimination scores are stable and bilaterally. The discrimination in the right ear was 100% at MCL. The discrimination of the left ear was 100 % at MCL. The discrimination of the right ear at 90 dB or greater was 100 %. The discrimination of the left ear at 90 dB or greater was 100 %. The tympanograms showed a type A pattern in both ears. The otoacoustic emissions revealed decreased SPL levels in high frequencies, mid frequencies, low frequencies and both ears.

Impression / Diagnosis: #1 Endolymphatic Hydrops (386.00) viral based, currently with acute exacerbation and left --resolved. Endolympahtic hydrops is a condition characterized by a fluid (endolymph) imbalance of the inner ear. Symptoms can include intermittant fullness, intermittant tinnitus, fluctuating hearing and intermittent spells of dizziness/vertigo or imbalance. #2 Imbalance (781.2) moderate and severe, with Benign Positional Vertigo, treated and patient continues w/ a residual VOR abnormality requiring Vestibular home exercise program and this is improving. A sensation of instability which can be constant with intermittant worsening. Secondary symptoms may include cognitive dysfunction, short term memory loss, concentration difficulties, inability to "focus". #3Fatigue (780.79), unresolved and addressed with the

replacement of HGH. #4 Allergic Rhinitis (477.80)- Commonly known as "allergies" or "sinus, Will address this with antihistamines at this time.

Medication Prescribed: Continue same meds as previously prescribed.

Plan: Patient to continue home program.
Plan: Continue current immunotherapy.

Follow-up Instructions: The patient will continue on the Orange protocol and will receive Audiometry, acoustic reflex, OAE, CTSIB, VAT and ImPACT on their return visit in 1 weeks. If patients testing is improved and anxiety level is manageable, will release to return to full duty at work.

Physician's Signature: _____ Kendal L. Stewart, M.D.

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Karin Fagner, NP-C

THE OTOLOGY GROUP OF TEXAS

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 6/6/2002.
Age: 44.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Continued aural fullness and Dizziness. No Improvement.

History of Present Illness: The patient is currently being treated at The Otology Group of Texas for Endolymphatic Hydrops, Allergic Rhinitis, Chronic Imbalance and a peripheral based vertigo. The patient is stable and has had no significant fluctuations in symptoms. The patient describes slow, but steady improvement.
Ear History: The patient describes no otalgia. The patient has no otorrhea.
Dizziness History: The patient describes no to very little change in their imbalance, vertigo severity, tinnitus and fullness since they were last seen.
Imbalance History: The patient describes significant improvement in balance. Pt. Has completed physical therapy, and is currently on home exercise program. She has had one episode of vertigo, and was able to resolve this using the techniques she learned at PT. She has some anxiety regarding her BPPV, attention deficits and memory deficits, but believes there is slow, steady improvement.
Hearing History: The hearing loss is best described as a muffled sensation to hearing.
Allergy History: The patient has been on their current immunotherapy for 2 months. The patient is currntly experiencing no adverse reactions to their immunotherapy.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.

Allergies: No known drug allergies.

Current Medications: Valtrex 500 bid. Zyrtec 10 qd . HGH Max 9/day.Duratuss.

Review of Systems:
ROS Respiratory: Patient denies any respiratory complaints, such as cough, shortness of breath, chest pain, wheezing, hemoptysis, etc.
ROS Cardiovascular: The patient has no history of cardiovascular symptoms, such as chest pain, palpitation, lightheadedness, syncope, etc.

ROS Gastrointestinal: Patient denies any gastrointestinal symptoms, such as anorexia, weight loss, dysphagia, nausea, vomiting, abdominal pain, abdominal distention, altered bowel movements, diarrhea, constipation, rectal bleeding, hematochesia, e.
ROS Genitourinary: Patient denies any genito-urinary complaints, such as hematuria, dysuria, frequency, urgency, hesitancy, nocturia, incontinence, etc.
ROS Gynecological: Denies any gynecological complaints, such as vaginal bleeding, discharge, pain, etc.
ROS Musculoskeletal: The patient denies any past or present problems related to the musculoskeletal system.
ROS Extremities: The patient denies any extremities complaints.
ROS Skin: Denies rashes, pruritis, lesions, bruising.
ROS Head and Eyes: Patient has following symptoms associated with the headache : Headaches associated with allergy symptoms.. Patient complains of moderately dizzines and overall it is getting better.
ROS Ears Nose and Throat: As per HPI.

Examination: The patient was awake, alert and conversant. No acute distress noticed. Exam Facial: Normal facies, no TMJ tenderness. Eye exam: Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Microscopic exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly. **Rhomberg reveals minor anterior- posterior sway and stable pattern with no sway.** Exam Skin: **Normal turgor and elasticity; no significant skin lesions.** Exam Respiratory: Chest symmetrical, normal, breath sounds equal, bilateral symmetrical, no rales or rhonchi and no dullness to percussion.
Exam Nose: The nasal mucosa showed irritation and significantly hyperemia. The exam revealed hypertrophied turbinates.

Tests: Air 125 HZ: AS: 20 dB and AD: 15 dB. Air 250 Hz: AS: 20 dB and AD: 10 dB. Air 500 Hz: AD: 15 dB and AS: 15 dB. Air 1000 Hz: AS: 15 dB and AD: 10 dB. Air 2000 Hz: AS: 15 dB and AD: 15 dB. Air 4000 Hz: AS: 10 dB and AD: 15 dB. Air 8000 Hz: AD: 20 dB and AS: 15 dB. There were elevated reflex threshlolds present in both ears. The discrimination in the right ear was 100% at MCL. The discrimination of the left ear was 100 % at MCL. The discrimination of the right ear at 90 dB or greater was 100 %. The discrimination of the left ear at 90 dB or greater was 96 %. The tympanograms showed a type A pattern in both ears. The otoacoustic emissions revealed elevated SPLs in high frequencies and both ears.
Audio/Vestibular Tests: COG testing reveal a left sided and anterior abnormal pattern. The vertical plane VAT revealed high normal gains. The patient underwent an ImPACT neurocognitive test which revealed a Word Memory Score of 93%, a Memory Composite Score of 78% and a Totoal Symptom Score of 46. The horizontal VAT exam revealed low normal gains. On foam with eyes opened 0.8, eyes closed 1.4, copm.0.8.

Impression / Diagnosis: #1 Endolymphatic Hydrops (386.00) viral based, currently with acute exacerbation and left --resolved. Endolympahtic hydrops is a condition characterized by a fluid (endolymph) imbalance of the inner ear. Symptoms can include intermittant fullness, intermittant tinnitus, fluctuating hearing and intermittent spells of dizziness/vertigo or imbalance. #2

Imbalance (781.2) improved with Benign Positional Vertigo resolved at this time, treated and patient continues w/ a residual VOR abnormality requiring Vestibular home exercise program and this is improving. A sensation of instability which can be constant with intermittant worsening. Secondary symptoms may include cognitive dysfunction, short term memory loss, concentration difficulties, inability to "focus". #3Fatigue (780.79), unresolved and addressed with the replacement of HGH. #4 Allergic Rhinitis (477.80)- Commonly known as "allergies" or "sinus,will proceed w/ allergy shots.

Medication Prescribed: Continue same meds as previously prescribed.

Plan: Continue current immunotherapy.

Follow-up Instructions: Patient instructed on possible complications of treatment and is to phone if concerned over side effects. The patient will continue in the Blue Protocol and will receive Audiometry, OAE, Acoustic Reflex testing, and posturography on their return visit in 6 weeks.

Physician's Signature: _____ Kendal L. Stewart, M.D./BZ,FNP BZFND

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 8/12/2002.
Age: 44.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Headache temporal, Frontal and Posterior Cervical Headaches Dizziness.

History of Present Illness: The patient is currently being treated at The Otology Group of Texas for Endolymphatic Hydrops, Allergic Rhinitis, Chronic Imbalance and a peripheral based vertigo. The patient is stable and has had no significant fluctuations in symptoms. The patient describes slow, but steady improvement.
Ear History: Sometimes the left ear feels full and like liquid may come out.The patient describes no otalgia. The patient has no otorrhea.
Dizziness History: The patient describes an improvement in their dizzy symptoms since they were last seen. Spells have lessen in intensity but patient is very cautious not to do things she knows will make her dizzy.
Allergy History: The patient has been on their current immunotherapy for 4 months. The patient is currently experiencing no adverse reactions to their immunotherapy. The major symptoms include premaxillary pressure and frontal sinus pressure. The patient also complains of a history of nasal polyps.

Past Surgical History: Tubal ligation.
Past Medical History: Non-contributory.
Past Social History: The patient describes difficulty sleeping. Non smoker. Alcohol: denies use of alcohol. Marital Status: Married.

Allergies: No known drug allergies.

Current Medications: Valtrex 500 bid. Zyrtec 10 qd . HGH Max 9/day.

Review of Systems: Active. The patient is a good historian. The patient reports a stable weight pattern. Patient describes malaise (being tired).
ROS Respiratory: Patient denies any respiratory complaints, such as cough, shortness of breath, chest pain, wheezing, hemoptysis, etc.
ROS Cardiovascular: The patient has no history of cardiovascular symptoms, such as chest pain, palpitation, lightheadedness, syncope, etc.
ROS Genitourinary: Patient denies any genito-urinary complaints, such as hematuria, dysuria, frequency, urgency, hesitancy, nocturia, incontinence, etc.
ROS Skin: Denies rashes, pruritis, lesions, bruising.

ROS Head and Eyes: Patient has following symptoms associated with the headache : Headaches associated with allergy symptoms.. Patient complains of moderately dizzines and overall it is getting better.
ROS Ears Nose and Throat: As per HPI. Possilbe nose polyps.
ROS Gynecological: Has been bloating and some pains in the ovary areas.
ROS Extremities: Sometimes has tingling of the toes.
ROS Gastrointestinal: Sometimes feels nauseas.

Examination: The patient was awake, alert and conversant. No acute distress noticed. Rhomberg reveals minor anterior- posterior sway and flickering of the eyes.
Exam Ear: Microscopic exam of the ears was performed bilaterallty. Exam revealed normal pinnae #S#. The external auditory canals are normal without evidence of erythema, cerumen or stenosis. Exam revealed normal tympanic membranes bilaterally. The middle ear spaces appear normal and free of effusion.
Exam Nose: The intranasal exam revealed a reasonably mid-line septum, only mild hyperemia and no evidence of polyps or purulence. The nasal mucosa was normal with no irritation or polypoid degeneration noted.

Tests: Air 125 HZ: AS: 25 dB and AD: 15 dB. Air 250 Hz: AS: 25 dB and AD: 20 dB. Air 500 Hz: AD: 15 dB and AS: 25 dB. Air 1000 Hz: AS: 15 dB and AD: 15 dB. Air 2000 Hz: AS: 15 dB and AD: 15 dB. Air 4000 Hz: AS: 10 dB and AD: 15 dB. Air 8000 Hz: AD: 10 dB and AS: 20 dB. There were elevated reflex threshlolds present in both ears. The discrimination in the right ear was 100% at MCL. The discrimination of the left ear was 96 % at MCL. The discrimination of the right ear at 90 dB or greater was 100 %. The discrimination of the left ear at 90 dB or greater was 100 %. The tympanograms showed a type A pattern in both ears. The otoacoustic emissions revealed decreased SPL levels in mid frequencies, low frequencies and both ears.
Procedure: Binocular microscopy (CPT 92504). Binocular microscopy was performed to assess the status of the tympanic membrane and middle ear and to evaluate for the possible presence or absence of perforation, middle ear disease, or cholestatoma. Findings as noted.

Impression / Diagnosis: #1 Endolymphatic Hydrops (386.00) viral based, currently with acute exacerbation and left --resolved. Endolympahtic hydrops is a condition characterized by a fluid (endolymph) imbalance of the inner ear. Symptoms can include intermittant fullness, intermittant tinnitus, fluctuating hearing and intermittent spells of dizziness/vertigo or imbalance. #2 Imbalance (781.2) improved with Benign Positional Vertigo resolved at this time, treated and patient continues w/ a residual VOR abnormality requiring Vestibular home exercise program and this is improving. A sensation of instability which can be constant with intermittant worsening. Secondary symptoms may include cognitive dysfunction, short term memory loss, concentration difficulties, inability to "focus". #3Fatigue (780.79), unresolved and addressed with the replacement of HGH. #4 Allergic Rhinitis (477.80)- Commonly known as "allergies" or "sinus,will proceed w/ allergy shots.

Medication Prescribed: Continue same meds as previously prescribed. Gave samples of nasocort,nasonex.D/C valtrex 10/1/02.

Plan: The patient's progress was discussed in detail. Plan on Continueing valtrex 6 more weeks.
Plan: Continue current immunotherapy.

Follow-up Instructions: Follow-up with doctor in 8 week(s). Patient instructed on possible complications of treatment and is to phone if concerned over side effects. The patient will continue on the Orange protocol and will receive Audiometry, acoustic reflex, OAE, CTSIB, VAT and ImPACT on their return visit in 8 weeks.

Physician's Signature: Kendal L. Stewart, M.D.

Neuro-Sensory Enhancement Center of Austin

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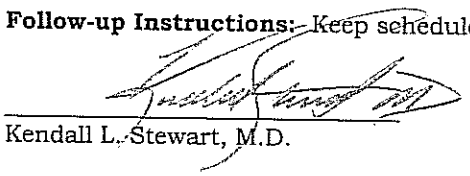
Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 6/27/2003.
DOB: 1/31/1958. **Age:** 45.

Attending Physician: Kendall L. Stewart, M.D.
Type of Visit: Nursing Phone Consult: dizziness. Patient reports has had intermittent spells. Patient states has not be compliant with immunotherapy.

Plan: The patient will receive 1cc of Celestone and 2cc Depomedrol.
Plan: Continue current immunotherapy. Patient and spouse were shown how to do weekly injections and serum was released.

Follow-up Instructions: Keep scheduled appointment.



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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 8/16/2005.
DOB: 1/31/1958. **Age:** 47.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Dizziness.

History of Present Illness: The patient is currently being treated for imbalance, dizziness, tinnitus, fatigue, benign positional vertigo and allergic rhinitis.
Dizziness History: The patient presents with complaints of acute onset of dizziness. The length of the very first episode of vertigo has produced continuous persistent vertigo. The problem first began 4 days ago. The patient's dizziness is described as aural fullness, continuous, nausea, anxiety, general disorientation, a spinning sensation, general instability, staggering and feeling off balance. The episodes are severe and incapacitating. The symptoms are made worse by movement, moving from a sitting position to standing position, stress and rolling over in bed. The last episode of imbalance/vertigo occurred today. Patient reports having gone to the ER on Saturday and had a sinus CT, which showed a small cyst, blood work that showed elevated sugar and WBC and was given Meclizine and Diazepam, which cause her to fall asleep and was directed to see her PCP. Patient has a past history of BPPV and comments she has intermittent mild episode which she gets under control by doing her HEP. Patient reports the past month she has been working a lot of overtime and that she had recently lost a new grandbaby.

Past Surgical History: Tubal ligation.
Past Medical History: Vertigo.
Past Social History: Marital Status: Married. Non-smoker. The patient is a non-drinker. Patient was raised in El Paso, Texas.

Allergies: No known drug allergies.

Current Medications: Centrum qd, Meclizine prn, Diazepam prn.

Review of Systems: Generally healthy. Active. The patient/guardian is a good historian. The patient/guardian reports a stable weight pattern.
ROS Head and Eyes: Anxiety: worsened. Processing difficulties: worsened. Dizziness: worsened. Imbalance: worsened.
ROS Ears Nose and Throat: Allergic symptoms: seasonal. Tinnitus: intermittent and worsened. Ear pressure: worsened. Ear fullness: worsened. The patient/guardian complains of intermittent otalgia.
ROS Respiratory: Denies any cough, chest pain or shortness of breath.
ROS Cardiovascular: Denies any chest pain, palpitation or lightheadedness.
ROS Gynecological: The patient/guardian denies any present or past gynecological problems.
ROS Musculoskeletal: The patient denies any musculoskeletal complaints.
ROS Extremities: The patient/guardian denies any extremities complaints.
ROS Skin: Denies rashes, pruritis, lesions, or bruising.
ROS Gastrointestinal: Patient/guardian reports nausea associated with dizziness. Vomiting: with dizziness.
ROS Genitourinary: Denies any genito-urinary complaints. Patient has history of recurring bladder infections.

Examination: A very thorough diagnostic evaluation was carried out to test middle TM compliance, acoustic reflexes, EAC function, extraocular movements, hearing sensitivity, balance relationship to somatosensory, visual and vestibular clues and reflex recovery from balance perturbation. The patient was awake and alert. No acute distress noticed. **Exam Facial:** Normal facies, no TMJ tenderness. **Eye exam:** Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without

any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly.

Tests: The audiogram revealed a mild. The discrimination in the right ear was 100% at MCL. The discrimination of the left ear was 100 % at MCL. The discrimination of the right ear at 80 dB or greater was 100 %. The discrimination of the left ear at 80 dB or greater was 100 %. There were elevated reflex thresholds present in both ears. Testing of acoustic reflexes shows inequality. The tympanograms showed a type A pattern in both ears. The otoacoustic emissions revealed decreased SPL levels in high frequencies, mid frequencies, low frequencies and both ears.
Audio/Vestibular Tests: COG testing reveals a posterior abnormal pattern. Center of gravity was severely scattered. CTSIB comprehensive score 1.9. CTSIB testing on foam with eyes closed 4.7. CTSIB testing on foam with eyes open 1.3.

Impression / Diagnosis: Vertigo (unspecified) (386.10) .
Impression / Diagnosis: BPPV (386.11) .
Impression / Diagnosis: Tinnitus - subjective (388.31) .
Impression / Diagnosis: Imbalance (781.2) .
Impression / Diagnosis: Labyrinthine hypofunction bilateral (386.54) .
Impression / Diagnosis: General Fatigue (780.79) .
Impression / Diagnosis: Concern regarding Heavy Metal Burden (Unspecified Metal - 985.9) .

Medication Prescribed: DMPS Rx faxed to pharmacy. DMPS 250mg #1, take prior to urinalysis, +2 refills. Valtrex 500mg #60 + 3 refills 1 tab bid (Anti-viral). Recommend patient discontinued either Meclizine OR Diazepam today.

Plan: The diagnostic findings and treatment regimen was discussed at length with the patient/ parent. Reasoning and diagnostics reviewed in detail. Medication's efficacy, function, safety, expectations and possible side effects explained. Risks, complications and benefits of treatment discussed. Discussed provocative heavy metal urinalysis to determine if heavy metal elevations are present. Blood work-up to check: somatomedin C, testosterone, free testosterone, progesterone, TSH, free T4 and estrogen. The patient received 1cc of Celestone (6mg/mL) and 2cc Depomedrol (80mg/mL). Order for Provocative Heavy Metal Urinalysis was faxed to Doctor's Data Inc. Patient had no family or friends accompanying during the exam and discussion of their problem. Informational material was given to patient. Recommend patient should be off work from now until 8/29/05 (letter was given). Patient received otolith repositioning today.

Follow-up Instructions: Patient was instructed to follow up by phone if there are any problems. Recommend patient to keep scheduled appointment. Follow-up with doctor in 6 week(s). Will call with diagnostic results. Patient is to receive the following diagnostic testing on their return visit: Audiogram, Tympanometry, Acoustic Reflex testing, Otoacoustic Emissions, Computerized Platform Posturography and Vestibular-Ocular Reflexes. Patient to report if symptoms persist she will be worked in early then her 6-week follow up. KS/dn/dn.

Kendal L. Stewart, M.D.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 9/14/2005.
DOB: 1/31/1958. **Age:** 47. **Weight:** 138.8. **Temp:** 97.3.

Attending Physician: Kendal L. Stewart, M.D.

Chief Complaint: Positional Dizziness, imbalance and headaches.

Dizziness History: The patient has had improvements in processing difficulties, duration of dizzy spells, hyperacusis, severity of dizzy spells, hearing and fatigue since they were last seen. Patient has had fluctuation in motion sickness, work/ school performance, frequency of dizzy spells, neuropathy, memory, nausea, irritability/ mood swings, emotionality, number of 'bad days', dizziness and depression since they were last seen. Patient has had no change in fullness/ pressure; sleep pattern, imbalance, vertigo, tinnitus, irritability/ mood swings, concentration, stumbling/ staggering and anxiety since they were last seen. Patient has had a worsening in headaches since they were last seen. Patient states dizziness and imbalance worsened today following testing. Patient complains of a severe headache this past weekend (frontal and post-cervical).

Past Surgical History: Tubal ligation.
Past Medical History: Vertigo.
Past Social History: Marital Status: Married. Non-smoker. The patient is a non-drinker. Patient was raised in El Paso, Texas.
Occupational History: Factory worker.

Allergies: No known drug allergies.

Current Medications: Valtrex 500mg bid.

Review of Systems: Generally healthy. Active. The patient/guardian is a good historian. The patient/guardian reports a stable weight pattern. The patient/guardian complains of feeling tired all the time. Patient/guardian describes sleep pattern as poor and interrupted.
ROS Head and Eyes: Anxiety: fluctuating. Processing difficulties: fluctuating. Dizziness: worsened today, following testing. Imbalance: worsened today, following testing.
ROS Ears Nose and Throat: Allergic symptoms: nasal congestion for the last 3-4 days. Tinnitus: no change. Ear pressure: no change. Ear fullness: no change. The patient/guardian complains of intermittent bilateral otalgia.
ROS Respiratory: Denies any cough, chest pain or shortness of breath.
ROS Cardiovascular: Denies any chest pain, palpitation or lightheadedness.
ROS Gynecological: The patient/guardian denies any present or past gynecological problems.
ROS Musculoskeletal: Minimal cervical pain for the last two weeks.
ROS Extremities: The patient/guardian denies any extremities complaints.
ROS Skin: Denies rashes, pruritis, lesions, or bruising.
ROS Gastrointestinal: Patient complains of moderate symptoms of diarrhea for the last two days.
ROS Genitourinary: Denies any genito-urinary complaints.

Examination: A very thorough diagnostic evaluation was carried out to test middle TM compliance, acoustic reflexes, EAC function, extraocular movements, hearing sensitivity, balance relationship to somatosensory, visual and vestibular clues and reflex recovery from balance perturbation. The patient was awake and alert. No acute distress noticed. **Exam Facial:** Normal facies, no TMJ tenderness. **Eye exam:** Normal vision; EOM intact; no nystagmus. **Exam Ears:** Pinnae are normal. Exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly. Rhomberg reveals minor anterior-posterior sway and flickering of the eyes.
Exam Nose: The intranasal exam revealed a reasonably mid-line septum, only mild hyperemia and no evidence of polyps or purulence. The nasal mucosa was normal with no irritation or polypoid degeneration noted.

Tests: There is evidence of recovery of the acoustic reflex. The tympanograms showed a type A pattern in both ears. The otoacoustic emissions revealed decreased SPL levels in high frequencies, mid frequencies, low frequencies and both ears.
Audio/Vestibular Tests: COG testing reveals a anterior and improving abnormal pattern. CTSIB comprehensive score 0.8. CTSIB testing on foam with eyes closed 1.5. CTSIB testing on foam with eyes open 0.7. The vertical plane VAT revealed fatigue-ability and high normal gains. The horizontal VAT exam revealed fatigue-ability and high normal gains.

Impression / Diagnosis: Vertigo (unspecified) (386.10).
Impression / Diagnosis: Imbalance (781.2).
Impression / Diagnosis: Labyrinthine hypofunction bilateral (386.54).
Impression / Diagnosis: General Fatigue (780.79).
Impression / Diagnosis: Tinnitus - subjective (388.31).
Impression / Diagnosis: Sleep Disorder (780.50).

Medication Prescribed: Valtrex 500mg bid for an additional six weeks and then prn as directed and samples of Lunesta 2mg, one at HS prn sleep.

Plan: The patient received 1/2cc Celestone (6mg/ml) and 1 1/2cc Depo-Medrol (80mg/ml). Patient had no family or friends accompanying during the exam and discussion of their problem. The patient's progress was discussed in detail. Improved diagnostics, audiometric and vestibular. Patient encouraged proceed with Post-DMPS provocative urine as recommended. Recommend that patient not return to work until October third.

Follow-up Instructions: Patient was instructed to follow up by phone if there are any problems. Patient instructed to follow-up the end of October with Audio, OAE, Platform, Tymp/reflexes and VAT. KS/cam.

Kendal L. Stewart, M.D.

Neuro-Sensory Enhancement Center of Austin

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 10/31/2005.
DOB: 1/31/1958. **Age:** 47. **Weight:** 138.4.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Positional dizziness with associated imbalance, headaches and otalgia.

History of Present Illness: The patient is currently being treated for imbalance, dizziness, tinnitus, fatigue, benign positional vertigo and allergic rhinitis.
Dizziness History: The patient has had improvements in sleep pattern, anxiety, depression, dizziness, hearing, severity of dizzy spells, emotionality, allergies, memory, processing difficulties, neuropathy, hyperacusis, frequency of dizzy spells, duration of dizzy spells, work/ school performance, stumbling/ staggering, irritability/ mood swings and concentration since they were last seen. Patient has had fluctuation in light-headedness, visual difficulties, motion sickness, tinnitus, nausea, imbalance, number of 'bad days', headaches, fullness/ pressure, fatigue and dizziness since they were last seen. The patient's dizziness is described as intermittent, general instability and lightheadedness. The episodes are mild, but annoying. The last episode of imbalance/vertigo occurred 2 weeks ago. The patient is currently taking Valtrex 500 BID for their condition. Patient reports having been awoken with a moderate vertigo attack on 10/21 that lingered for about 48 hours before resolving. Patient reports she has returned to work and that she typically works Monday - Thursday about 10-14 hours a day. Patient reports intermittent left ear pain, fullness/pressure, fluid and eye pressure that is associated with her dizziness. Patient reports she has not yet completed the heavy metal urinalysis.

Past Surgical History: Tubal ligation.
Past Medical History: Vertigo.
Past Social History: Marital Status: Married. Non-smoker. The patient is a non-drinker. Patient was raised in El Paso, Texas.

Allergies: No known drug allergies.

Current Medications: Valtrex 500mg bid, Centrum qd.

Review of Systems: Generally healthy. Active. The patient/guardian is a good historian. The patient/guardian reports a stable weight pattern.
ROS Head and Eyes: Anxiety: improved. Fatigue: Fluctuating. Sleep pattern: stabilized. Dizziness: intermittent and positional. Imbalance: fluctuating. Headaches: fluctuating.
ROS Ears Nose and Throat: Patient reports intermittent left ear pain, fullness/pressure, fluid and eye pressure that is associated with her dizziness.
ROS Respiratory: Denies any cough, chest pain or shortness of breath.
ROS Cardiovascular: Denies any chest pain, palpitation or lightheadedness.
ROS Gynecological: The patient/guardian denies any present or past gynecological problems.
ROS Musculoskeletal: The patient/guardian denies any musculoskeletal complaints.
ROS Extremities: Patient reports having a burning sensation in her left leg after she gets off work.
ROS Skin: Denies rashes, pruritis, lesions, or bruising.
ROS Gastrointestinal: Patient/guardian denies any nausea, vomiting, abdominal pain, dysphagia or any altered bowel movements.
ROS Genitourinary: Denies any genito-urinary complaints.

Examination: A very thorough diagnostic evaluation was carried out to test middle TM compliance, acoustic reflexes, EAC function, extraocular movements, hearing sensitivity, balance relationship to somatosensory, visual and vestibular clues and reflex recovery from balance perturbation. The patient was awake and alert. No acute distress noticed. **Exam Facial:** Normal facies, no TMJ tenderness. **Eye exam:** Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Exam of the ears revealed normal external canals, normal tympanic

membranes and normal middle ear spaces bilaterally. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly.

Tests: Audiogram unchanged since the last visit. The discrimination in the right ear was 100% at MCL. The discrimination of the left ear was 100 % at MCL. The discrimination of the right ear at 80 dB or greater was 100 %. The discrimination of the left ear at 80 dB or greater was 100 %. There were elevated reflex thresholds present in both ears. Testing of acoustic reflexes shows inequality. There is evidence of recovery of the acoustic reflex. The tympanograms showed a type A pattern in both ears. OAEs show significant improvement in recruitment phenomenon since the last visit. OAE reveals a U shape pattern in both ears.
Audio/Vestibular Tests: COG testing reveals a right sided, centered and improving abnormal pattern. Center of gravity was mildly scattered. CTSIB comprehensive score 0.7. CTSIB testing on foam with eyes closed 1.6. CTSIB testing on foam with eyes open 0.7. The vertical plane VAT revealed inconsistency. The horizontal VAT exam revealed high normal gains.

Impression / Diagnosis: Vertigo (unspecified) (386.10) . Resolved.
Impression / Diagnosis: Imbalance (781.2) .
Impression / Diagnosis: Labyrinthine hypofunction bilateral (386.54) .
Impression / Diagnosis: General Fatigue (780.79) .
Impression / Diagnosis: Tinnitus - subjective (388.31) .
Impression / Diagnosis: Sleep Disorder (780.50) .

Medication Prescribed: Acetazolamide 250mg #60 +3 refills 1 tab QD-BID prn headache/ fullness. Recommend Valtrex 250mg qhs and then d/c 12/15/05 and use on prn basis.

Plan: Discussed the use of antiviral (PRN basis) during acute infections, environmental allergy exacerbations, acute injury or surgical intervention, or in any case of inflammatory processes. Reviewed laboratory results in detail. The patient's progress was discussed in detail. Informational material was given to patient. Patient had no family or friends accompanying during the exam and discussion of their problem. Patient released to full duty.

Follow-up Instructions: Patient was instructed to follow up by phone if there are any problems. Recommend patient to set a follow up as needed. KS/dn/dn.

Kendal L. Stewart, M.D.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 1/3/2006.
DOB: 1/31/1958. **Age:** 47.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Positional dizziness with associated imbalance, headaches and otalgia.

History of Present Illness: The patient is currently being treated for imbalance, dizziness, sleep disorder, tinnitus, fatigue, benign positional vertigo and allergic rhinitis.
Dizziness History: The patient describes an acute vertigo spell, which does not subside for several minutes with positional changes. The patient has had improvements in processing difficulties, hyperacusis, neuropathy, memory, light-headedness, hearing and fatigue since they were last seen. Patient has had fluctuation in severity of dizzy spells, motion sickness, duration of dizzy spells, sleep pattern, nausea, imbalance, emotionality and dizziness since they were last seen. Patient has had no change in headaches, tinnitus, visual difficulties, concentration, anxiety and work/ school performance since they were last seen. Patient has had a worsening in stumbling/ staggering, frequency of dizzy spells, vertigo, imbalance, number of 'bad days' and allergies since they were last seen. The episodes are of variable intensity. The last episode of imbalance/vertigo occurred today. The patient describes being off balance and "foggy-headed" sensation between attacks or spells. The patient is currently taking Valtrex prn for their condition. Patient reports having noticed about one week prior to an attack she will have fullness/pressure/pain in her left ear and eye. Patient reports having discontinued Valtrex on 12/15/05 as directed and with in 10 days having a severe vertigo attack. Patient report the most recent attack occurred while in Mexico on 12/24. Patient reports having been seen by a physician there and was given some kind of injection in the morning, noon and night, which did help her symptoms. Patient reports having also gone to her GP on 12/27 and received prescriptions for Valtrex and Meclizine, which she did not fill. Patient reports she resumed Valtrex after returning to the states on 12/27 with some relief to her symptoms. Patient has not been to work since 12/26 due to this most recent attack.

Past Surgical History: Tubal ligation.
Past Medical History: Vertigo.
Past Social History: Marital Status: Married. Non-smoker. The patient is a non-drinker. Patient was raised in El Paso, Texas.

Allergies: No known drug allergies.

Current Medications: Valtrex 500mg bid prn, Centrum qd.

Review of Systems: Generally healthy. Inactive. Patient/guardian describes malaise (being tired).
ROS Head and Eyes: Anxiety: fluctuating. Fatigue: Fluctuating. Sleep pattern: worsened. Processing difficulties: fluctuating. Dizziness: variable intensity and worsened. Imbalance: worsened.
ROS Ears Nose and Throat: Allergic symptoms: circles under eyes, headaches, runny nose, itchy, watery eyes, watery eyes, stuffy nose, post nasal drainage, sneezing and seasonal. Ear pressure: fluctuating. Ear fullness: fluctuating. The patient/guardian complains of fluctuating otalgia.
ROS Respiratory: Denies any cough, chest pain or shortness of breath.
ROS Cardiovascular: Denies any chest pain, palpitation or lightheadedness.
ROS Gynecological: The patient/guardian denies any present or past gynecological problems.
ROS Musculoskeletal: The patient/guardian denies any musculoskeletal complaints.
ROS Extremities: The patient/guardian denies any extremities complaints.
ROS Skin: Denies rashes, pruritis, lesions, or bruising.
ROS Gastrointestinal: Patient/guardian reports nausea associated with dizziness.
ROS Genitourinary: Denies any genito-urinary complaints.

Examination: A very thorough diagnostic evaluation was carried out to test middle TM compliance, acoustic reflexes, EAC function, extraocular movements, hearing sensitivity, balance relationship to somatosensory, visual and vestibular clues and reflex recovery from balance perturbation. The patient was awake and alert. No acute distress noticed. **Exam Facial:** Normal facies, no TMJ tenderness. **Eye exam:** Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly.

Tests: The audiogram revealed a mild and high frequency hearing loss. The discrimination in the right ear was 100% at MCL. The discrimination of the left ear was 100 % at MCL. The discrimination of the right ear at 80 dB or greater was 100 %. The discrimination of the left ear at 80 dB or greater was 100 %. The acoustic reflexes were absent in the left ear. There were elevated reflex thresholds present in the right ear. Testing of acoustic reflexes shows inequality. The tympanograms showed a type A pattern in both ears. The otoacoustic emissions revealed decreased SPL levels in high frequencies, mid frequencies, low frequencies and both ears.
Audio/Vestibular Tests: COG testing reveals a left sided and posterior abnormal pattern. Center of gravity was mildly scattered. CTSIB comprehensive score 1.0. CTSIB testing on foam with eyes closed 2.0. CTSIB testing on foam with eyes open 0.8. The vertical plane VAT revealed high normal gains. The horizontal VAT exam revealed inconsistency and fatigue-ability.
Procedure: The patient had Otolith Repositioning procedure of the left ear done in the office today per protocol.

Impression / Diagnosis: BPPV (386.11) .
Impression / Diagnosis: Vertigo (unspecified) (386.10) .
Impression / Diagnosis: Dizziness (780.4) .
Impression / Diagnosis: Imbalance (781.2) .
Impression / Diagnosis: General Fatigue (780.79) .
Impression / Diagnosis: Otalgia.
Impression / Diagnosis: Allergic Rhinitis (477.8) .

Medication Prescribed: Patient received samples of Lunesta 3mg and Allegra. Patient to continue the medications previously prescribed by other physicians. Recommend Valtrex 250mg bid until next appointment.

Plan: The patient received 1/2cc Celestone (6mg/ml) and 1 1/2cc Depo-Medrol (80mg/ml). The patient's progress was discussed in detail. Patient had Daughter accompany him/her during the exam and discussion of their problem. Recommend patient remain out of work from 12/26/05 - 1/16/06 (note given). Short Term Disability form were completed and faxed to the patient workplace.

Follow-up Instructions: Patient was instructed to follow up by phone if there are any problems. Follow-up with doctor in 6-8 week(s). Patient is to receive the following diagnostic testing on their return visit: Audiogram, Tympanometry, Acoustic Reflex testing, Otoacoustic Emissions, Computerized Platform Posturography, Vestibular-Ocular Reflexes and ImPACT Neuro-cognitive Testing. KS/dn/dn.

Kendal L. Stewart, M.D.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 1/25/2006.
DOB: 1/31/1958. **Age:** 47. **Weight:** 144. **Pulse:** 76 Respirations: 24. **BP:** 10/70. **Temp:** 98.1.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Positional dizziness with associated imbalance, headaches and otalgia.

History of Present Illness: The patient is currently being treated for imbalances, dizziness, sleep disorder, tinnitus, fatigue, benign positional vertigo and allergic rhinitis and BPPV.
Dizziness History: The patient has had improvements in duration of dizzy spells, neuropathy, and severity of dizzy spells, fatigue and anxiety since they were last seen. Patient has had fluctuation in motion sickness, hyperacusis, nausea, irritability/ mood swings, hearing and headaches since they were last seen. Patient has had no change in fullness/ pressure, light-headedness, number of 'bad days', frequency of dizzy spells, sleep pattern, imbalance, dizziness, vertigo, tinnitus, visual difficulties, processing difficulties, concentration, stumbling/ staggering, allergies and work/ school performance since they were last seen. Patient has had a worsening in memory since they were last seen. Patient complains of continued positional vertigo/dizziness. Patient states she is unable to take Acetazolamide due to a tingling sensation in her face.

Past Surgical History: Tubal ligation.
Past Medical History: Vertigo.
Past Social History: Marital Status: Married. Non-smoker. The patient is a non-drinker. Patient was raised in El Paso, Texas.
Occupational History: Factory worker.

Allergies: No known drug allergies.

Current Medications: Valtrex 250mg bid, Allegra prn and Lunesta 3mg prn.

Review of Systems: Generally healthy. Active. The patient/guardian is a good historian. The patient/guardian reports a stable weight pattern. The patient/guardian complains of feeling tired all the time. Patient/guardian describes sleep pattern as improved and interrupted.
ROS Head and Eyes: Anxiety: improved. Fatigue: improved. Sleep pattern: interrupted and improved with Lunesta. Processing difficulties: no change. Dizziness: improving. Imbalance: no change.
ROS Ears Nose and Throat: Allergic symptoms: seasonal with no apparent symptoms. Ear pressure: fluctuating. Ear fullness: fluctuating. The patient/guardian complains of fluctuating otalgia.
ROS Respiratory: Denies any cough, chest pain or shortness of breath.
ROS Cardiovascular: Denies any chest pain, palpitation or lightheadedness.
ROS Gynecological: The patient/guardian denies any present or past gynecological problems.
ROS Musculoskeletal: The patient/guardian denies any musculoskeletal complaints.
ROS Extremities: Patient complains of intermittent pain in her left outer calf since October 2005.
ROS Skin: Denies rashes, pruritis, lesions, or bruising.
ROS Gastrointestinal: Patient/guardian reports nausea associated with dizziness and intermittent complaints of constipation/diarrhea for approximately one month.
ROS Genitourinary: Denies any genito-urinary complaints.

Examination: A very thorough diagnostic evaluation was carried out to test middle TM compliance, acoustic reflexes, EAC function, extraocular movements, hearing sensitivity, balance relationship to somatosensory, visual and vestibular clues and reflex recovery from balance perturbation. The patient was awake and alert. No acute distress noticed. **Exam Facial:** Normal facies, no TMJ tenderness. **Exam Ears**: Pinnae are normal. Exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in

reasonable repair. The oropharynx was also normal without any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly.

Tests: Testing of acoustic reflexes shows inequality. There is evidence of recovery of the acoustic reflex. The tympanograms showed a type A pattern in both ears. The otoacoustic emissions revealed decreased SPL levels in high frequencies, mid frequencies, low frequencies and both ears.
Audio/Vestibular Tests: COG testing reveals a Minimal abnormal COG alignment, posterior and improving abnormal pattern. CTSIB comprehensive score 0.7. CTSIB testing on foam with eyes closed 1.2. CTSIB testing on foam with eyes open 0.8.
Procedure: Left Dix Hallpike: Latent: Positive. Rotary: Positive. Nystagmus non-Fatigueable. Right Dix Hallpike: Negative.

Impression / Diagnosis: BPPV (386.11).
Impression / Diagnosis: Vertigo (unspecified) (386.10).
Impression / Diagnosis: Dizziness (780.4).
Impression / Diagnosis: Imbalance (781.2).
Impression / Diagnosis: General Fatigue (780.79).
Impression / Diagnosis: Otalgia.
Impression / Diagnosis: Allergic Rhinitis (477.8)
Medication Prescribed: Acetazolamide 250mg, 1/4-1/2 tablet prn as directed and continue current medications.

Plan: The patient's progress was discussed in detail. Patient had Daughter accompany him/her during the exam and discussion of their problem and patient to receive a Hall Pike today. Patient instructed not to return to work for two more weeks due to intractable vertigo.

Follow-up Instructions: Patient was instructed to follow up by phone if there are any problems. Recommend patient to set a follow up as needed. KS/cam.

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Patient Name: VELEZ, VIRGINIA.
Chart Number: 6704.
Date of Visit: 3/14/2006.
DOB: 1/31/1958. **Age:** 48. **Weight:** 140. **BP:** 108/7064 Respirations: 16. **Temp:** 98.5.

Attending Physician: Kendal L. Stewart, M.D.
Type of Visit: This patient presents for an Established Patient Office Visit.

Chief Complaint: Positional dizziness with associated imbalance, headaches and otalgia.

History of Present Illness: The patient is currently being treated for imbalance, dizziness, sleep disorder, tinnitus, fatigue, benign positional vertigo and allergic rhinitis and BPPV.
Dizziness History: The patient has had improvements in processing difficulties, irritability/ mood swings, number of 'bad days', work/ school performance, duration of dizzy spells, sleep pattern, memory, concentration, emotionality, fatigue and anxiety since they were last seen. Patient has had fluctuation in severity of dizzy spells, visual difficulties, vertigo, stumbling/ staggering, frequency of dizzy spells, hyperacusis, tinnitus, imbalance, hearing, headaches, dizziness, depression and allergies since they were last seen. Patient has had no change in fullness/ pressure and light-headedness since they were last seen. Patient continues to complain of intermittent mild positional dizziness without vertigo.

Past Surgical History: Tubal ligation.
Past Medical History: Vertigo.
Past Social History: Marital Status: Married. Non-smoker. The patient is a non-drinker. Patient was raised in El Paso, Texas.
Occupational History: Factory worker.

Allergies: No known drug allergies.

Current Medications: Valtrex 250mg bid, Acetazolamide prn, Allegra prn and Lunesta 3mg prn.

Review of Systems: Generally healthy. Active. The patient/guardian is a good historian. The patient/guardian reports a stable weight pattern. Patient/guardian describes sleep pattern as improved.
ROS Head and Eyes: Anxiety: improved. Fatigue: improved. Sleep pattern: improved with Lunesta. Processing difficulties: improved Dizziness: fluctuating. Imbalance: fluctuating.
ROS Ears Nose and Throat: Allergic symptoms: seasonal with no apparent symptoms. Ear pressure: fluctuating. Ear fullness: fluctuating. The patient/guardian complains of fluctuating left otalgia.
ROS Respiratory: Denies any cough, chest pain or shortness of breath.
ROS Cardiovascular: Denies any chest pain, palpitation or lightheadedness.
ROS Gynecological: The patient/guardian denies any present or past gynecological problems.
ROS Musculoskeletal: The patient/guardian denies any musculoskeletal complaints.
ROS Extremities: The patient/guardian denies any extremities complaints.
ROS Skin: Denies rashes, pruritis, lesions, or bruising.
ROS Gastrointestinal: Patient/guardian denies any nausea, vomiting, abdominal pain, dysphagia or any altered bowel movements.
ROS Genitourinary: Denies any genito-urinary complaints.

Examination: A very thorough diagnostic evaluation was carried out to test middle TM compliance, acoustic reflexes, EAC function, extraocular movements, hearing sensitivity, balance relationship to somatosensory, visual and vestibular clues and reflex recovery from balance perturbation. The patient was awake and alert. No acute distress noticed. **Exam Facial:** Normal facies, no TMJ tenderness. **Eye exam:** Normal vision; EOM intact; no nystagmus. **Exam Ears**: Pinnae are normal. Exam of the ears revealed normal external canals, normal tympanic membranes and normal middle ear spaces bilaterally. **Exam Nose:** The intranasal exam revealed a reasonably mid-line septum, mild, boggy edema of the turbinates and no evidence of polyps or purulence. **Exam Oropharynx:** The oral cavity was without any lesions. The teeth were in reasonable repair. The oropharynx was also normal without

any lesions. **Exam Neck:** Supple with full range of motion. There was no lymphadenopathy, masses or thyromegaly.

Tests: Testing of acoustic reflexes shows inequality. The tympanograms showed a type A pattern in both ears. The otoacoustic emissions revealed decreased SPL levels in mid frequencies, low frequencies and both ears. **Audio/Vestibular Tests:** The COG was normal and centered. CTSIB comprehensive score 0.5. CTSIB testing on foam with eyes closed 0.9. CTSIB testing on foam with eyes open 0.6. The vertical plane VAT revealed inconsistency, fatigue-ability and high normal gains. The horizontal VAT exam revealed low normal gains.

Impression / Diagnosis: BPPV (386.11) resolved.
Impression / Diagnosis: Vertigo (unspecified) (386.10) resolved.
Impression / Diagnosis: Dizziness (780.4) improved.
Impression / Diagnosis: Imbalance (781.2) improved.
Impression / Diagnosis: General Fatigue (780.79) improved.
Impression / Diagnosis: Otalgia, improved.
Impression / Diagnosis: Allergic Rhinitis (477.8).

Medication Prescribed: Fexofenadine HCL 180mg, #30, one daily for allergies, plus four refills and Valtrex 250mg at HS.

Plan: The patient's progress was discussed in detail. Patient had no family or friends accompany him/her during the exam and discussion of their problem. Labs: to be done in six to eight weeks, Comprehensive Metabolic Panel, Free T4, TSH and Free T3.

Follow-up Instructions: Patient was instructed to follow up by phone if there are any problems. Recommend patient to set a follow up as needed. Will call with diagnostic results. KS/cam.

Kendal L. Stewart, M.D.

VELEZ, VIRGINIA 6704

: Virginia Velez DOB 1/31/58 DATE 4-9-02 ORIG. TEST 6704

GEN	8	7	6	5	4	3	2	1	DIL. NO.	ANT. NO.	RETEST
BERMUDA	7+	8+				25				1	7
TIMOTHY	5+	7+				23				2	10
JOHNSON	6+	7+				24				3	10
RAGWEED	7+	8+				24				4	7
5. LAMB'S QUARTER		7+	8+			14				5	10
6. RUSSIAN THISTLE		7+	10+			18				6	10
7. MARSHELDER				7+	9+	10				7	4
8. FIREBRUSH (KOCHIA)			5+	7+		13				8	4
9. PIGWEED (CARELESSWEED)			5+	10+		13				9	3
10. DOCK (SOUR)				5+	6+	9				10	2
11. MAPLE (BOX LEDER)						6		17		11	3
12. MOUNTAIN CEDAR		9+	12+			15				12	7
13. OAK				7+	8+	11				13	4
14. ELM					6+	7	14+			14	3
15. COTTONWOOD						9		14+		15	3
16. ASH		5+	10+			10				16	5
17. MESQUITE				6+	8+	10				17	3
18. PECAN	7+	9+				22				18	7
19. PRIVET			6+	7+		13				19	4
20. PENICILLIUM						8	—			20	2
21. HORMODENDRUM						6		9+		21	1
22. ASPERGILLUS						6		8+		22	1
23. ALTERNARIA						6		8+		23	1
24. HELMINTHOSPORIUM						6		9+		24	1
25. JOHNSON GRASS SMUT						8	—			25	2
26. D. PTERONYSSINUS						8	—			26	2
27. D. FARINAE						8	—			27	2
28. CAT					6+	7	7+			28	2
29. DOG					6+	7	8+			29	2
30. HORSE					6+	7	8+			30	2
31. COCKROACH						6		10+		31	2
32. MUCOR						6		8+		32	1
33. PULLULARIA						6		9+		33	1
34. GLYCERINE CONTROL						6	7	9		D	0
35. HISTAMINE CONTROL						8	9	10			
36. SALINE						5					

Dominion Family Healthcare

Dominion Family Healthcare
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Virginia Velez ID: 1140 DOB: 01/31/1958 (52 years)

Date of Encounter: 01/05/2009 02:49 PM

History of Present Illness

Dominion Nurse 01/05/2009 02:52 PM

Patient's words: Cold sxs, nasal drainage, cough x several weeks off & on.
The patient is a 50 year old female who presents with a complaint of common cold. The onset of the common cold has been acute and has been occurring in a persistent pattern for 3 weeks. The course has been constant. The common cold is described as moderate.

Additional complaint:

Cough is described as the following :
The onset of the cough has been acute and has been occurring in a persistent pattern for 4 weeks. The course has been constant. The cough is characterized as productive of mucoid sputum. The amount of sputum produced is scanty. The symptoms have been associated with facial puffiness, fever, headache, hoarseness, night sweats, runny nose and sore throat.
-

History

Dominion Nurse 01/05/2009 02:49 PM

Allergy
- No Known Drug Allergies

Past Medical
- No chronic medical conditions
- Tubal Ligation

Social
- No Drug Use
- Non Drinker/No Alcohol Use
- Non Smoker/No Tobacco Use
- Caffeine use - occasional

Medications
- Nexium (40MG Capsule DR 1 (one) Oral daily, Taken starting 05/28/2008) Ordered - Hx Entry.
- CodiCLEAR DH (3.5-300MG/5ML Syrup 1 (one) Oral every four hours, as needed for cough, Taken starting 02/12/2008) Ordered - Hx Entry.
- Entex PSE (120-400MG Capsule ER 12HR 1 (one) Oral two times daily, as needed for congestion, Taken starting 02/12/2008) Ordered - Hx Entry.

Family
- Heart Disease - Mother, Father
- Cerebrovascular Accident - Mother
- Diabetes Mellitus - Mother, Father, Paternal Grandmother, Paternal Grandfather

Review of Systems

Kimberly L Warfield, MD 01/05/2009 03:04 PM

General: *Present-* Chills and Fever (*low grade off and on*).
HEENT: *Present-* Sinus Pain and Sore Throat.
Respiratory: *Present-* Cough and Sputum Production (*yellow*).

Vital Signs

Date:	01/05/2009 02:52 PM	**Height:**		**Note:** -
Temperature:	98 °F	**Weight:**	141 lb	
Pulse:	-	**Waist:**		
Respirations:	-	**BMI:**	-	
Peak Flow:		**BSA:**	-	
Blood Pressure:	122/72			
Reading Type:	Manual			

Physical Exam

Kimberly L Warfield, MD, 01/05/2009 03:06 PM

General
Mental Status - Alert. **General Appearance** - Well groomed. Not in acute distress. **Orientation** - Oriented X4. **Build & Nutrition** - Well nourished and Well developed. **Posture** - Normal posture. **Hydration** - Well hydrated. **Voice** - Normal.

Integumentary
General Characteristics: Overall examination of the patient's skin reveals - no rashes and no suspicious lesions.

Head and Neck
Head - normocephalic, atraumatic with no lesions or palpable masses.
Face
Global Assessment - atraumatic.
Neck
Global Assessment - supple, non-tender, no palpable mass on the right and no palpable mass on the left.
Trachea - midline.
Thyroid
Gland Characteristics - normal size and consistency.

Eye
Eyeball - Bilateral - Extraocular movements intact. **Sclera/Conjunctiva - Bilateral** - No Discharge or Conjunctival injection. **Pupil - Bilateral** - Direct reaction to light normal, Equal, Regular and Round.

ENMT
Ears
External Auditory Canal - Bilateral - no drainage observed and no tenderness noted.
Otoscopic Exam: Tympanic Membrane - Bilateral - no effusion, no inflammation observed.
Nose and Sinuses
Nasal Mucosa - Bilateral - boggy and congested.
Mouth and Throat
Oral Cavity/Oropharynx: Oropharynx - mild pharyngeal erythema noted. no edema of posterior pharyngeal walls observed.
Tonsils: Discharge - Bilateral - no discharge noted.

Chest and Lung Exam
Auscultation:
Breath sounds: - Normal.

Cardiovascular
Auscultation: Rhythm - Regular.
Murmurs & Other Heart Sounds: Auscultation of the heart reveals - No Murmurs.

Lymphatic
General Lymphatics
Description - Normal .

Assessments & Plans

Kimberly L Warfield, MD, 01/05/2009 03:08 PM

ACUTE BRONCHITIS (466.0)

Medications
Guaifenesin-Codeine 100-10MG/5ML, 1-2 Teaspoon(s) every four hours, as needed for cough, 6 ounces, 01/05/2009, No Refill. Active.
Zithromax Z-Pak 250MG, 1 (one) Tablet as directed, 1 z-pak, 5 days starting 01/05/2009, No Refill. Ordered.
Additional Instructions
FOLLOW UP IF NO IMPROVEMENT OR IF SYMPTOMS WORSEN

The encounter was completed by Kimberly L Warfield MD.

Physical Exam

Kimberly L Warfield, MD, 01/12/2009 05:10 PM

General
Mental Status - Alert. **General Appearance** - Cooperative and Well groomed. Not in acute distress. **Orientation** - Oriented X4. **Build & Nutrition** - Well nourished and Well developed. **Posture** - Normal posture. **Hydration** - Well hydrated. **Voice** - Normal.

Integumentary
General Characteristics: Overall examination of the patient's skin reveals - no rashes. **Temperature** - normal warmth is noted.

Head and Neck
Face
Global Assessment - atraumatic.
Neck
Global Assessment - supple. non-tender, no palpable mass on the right and no palpable mass on the left.
Trachea - midline.

Eye
Sclera/Conjunctiva - Bilateral - No Discharge. **Pupil - Bilateral** - Normal, Direct reaction to light normal, Equal, Regular and Round.

ENMT
Ears
Pinna - Bilateral - no edema and no localized tenderness observed. **External Auditory Canal - Bilateral** - no drainage observed and no tenderness noted.
Otoscopic Exam: Tympanic Membrane - Right - no inflammation observed.
Nose and Sinuses
External Inspection of the Nose - symmetric, no deformities observed and no swelling present. **Nasal Mucosa - Bilateral** - boggy, congested and pallor present.
Mouth and Throat
Oral Cavity/Oropharynx: Hard Palate - no asymmetry observed and no erythema noted. **Soft Palate** - no asymmetry noted and no erythema noted. **Tongue** - no pallor noted and not ulcerated. **Oral Mucosa** - no cyanosis observed and no discoloration noted. **Oropharynx** - there is no swelling of the pharyngeal mucosa.
Tonsils: Characteristics - Bilateral - not congested, no erythema noted and no hypertrophy.
Hypopharynx - normal.

Chest and Lung Exam
Chest and lung exam reveals - quiet, even and easy respiratory effort with no use of accessory muscles, No adventitious breath sounds and on auscultation, normal breath sounds, no adventitious sounds and normal vocal resonance.

Cardiovascular
Cardiovascular examination reveals - normal heart sounds, regular rate and rhythm with no murmurs.

Lymphatic
Head & Neck
General Head & Neck Lymphatics:
Bilateral: Description - Normal. **Tenderness** - Non Tender.

Assessments & Plans

Kimberly L Warfield, MD, 01/12/2009 05:12 PM

ALLERGIC RHINITIS DUE TO POLLEN (477.0)

Medications
Allegra-D 12 Hour 60-120MG, 1 (one) Tablet ER 12HR two times daily, as needed for congestion, #50, 01/12/2009, No Refill. Active.
Procedures
THER/PROPH/DIAG INJ, SC/IM (90772) (1 Units)
INJECTION, METHYLPREDNISOLONE ACETATE, 80 MG (Special Coverage Instructions Apply. See MCM: 2049) (J1040) (1 Units)
Additional Instructions
FOLLOW UP IF NO IMPROVEMENT OR IF SYMPTOMS WORSEN

Addenda: (01/12/2009 05:14:44 PM; Kimberly L Warfield, MD) missed much of work last week due to being sick. She can go back to work on Wednesday

The encounter was completed by Kimberly L Warfield MD.

6301 W. Parmer, Suite 102
Austin, TX 78729-6802
Phone: (512) 834-9999
Fax: (512) 834-9998

Virginia Velez ID: 1140 DOB: 01/31/1958 (52 years)

Date of Encounter: 01/12/2009 04:52 PM

History of Present Illness

Kimberly L Warfield, MD 01/12/2009 05:05 PM

The patient is a 50 year old female who presents with a complaint of a runny nose. The onset of the runny nose has been acute and has been occurring in a persistent pattern for 2 days. The course has been constant. The runny nose is described as severe. Runny nose notes: lots of runny nose and sneezing over the weekend. Little fullness in throat.
-

History

Dominion Nurse 01/12/2009 04:52 PM

Allergy
- No Known Drug Allergies

Past Medical
- No chronic medical conditions
- Tubal Ligation

Social
- No Drug Use
- Non Drinker/No Alcohol Use
- Non Smoker/No Tobacco Use
- Caffeine use - occasional

Medications
- Guaifenesin-Codeine (100-10MG/5ML Liquid 1-2 Oral every four hours, as needed for cough, Taken starting 01/05/2009) Active.
- Nexium (40MG Capsule DR 1 (one) Oral daily, Taken starting 05/28/2008) Active.
- CodiCLEAR DH (3.5-300MG/5ML Syrup 1 (one) Oral every four hours, as needed for cough, Taken starting 02/12/2008) Active.
- Entex PSE (120-400MG Capsule ER 12HR 1 (one) Oral two times daily, as needed for congestion, Taken starting 02/12/2008) Active.

Family
- Heart Disease - Mother, Father
- Cerebrovascular Accident - Mother
- Diabetes Mellitus - Mother, Father, Paternal Grandmother, Paternal Grandfather

Review of Systems

Kimberly L Warfield, MD 01/12/2009 05:06 PM

General: *Present-* Chills (*little*). *Not Present-* Fever.
HEENT: *Present-* Eye Pain (*burning*), Nasal Congestion, Rhinitis, Sore Throat and Voice Changes.
Respiratory: *Present-* Cough.

Vital Signs

Date:	01/12/2009 04:52 PM	**Height:**		**Note:** -
Temperature:	98.3 °F	**Weight:**	138 lb	
Pulse:	-	**Waist:**		
Respirations:	-	**BMI:**	-	
Peak Flow:		**BSA:**	-	
Blood Pressure:	118/82			
Reading Type:	Manual			

Patient: **VIRGINIA VELEZ**
36196 - 1/31/1958
9415 QUAIL MEADOW DR
Austin, TX 78758

36196

Belda Zamora MD

2100 E. 6th Street
Austin, Texas 78702
(512) 474-7824

Visit Date/Time: 4/28/2009 8:53:37 AM

Chief Complaint: Itchy nose-watery eyes and fever-allergies?

Allergies: **NKDA**

Past Medical History:

Childhood Illnesse:

Past Surgical History: tah and ovarian surgery 2003

Social History: occupation: deli
no tobacco
and no etoh
married

Family History:

Problem List:

Current Medications:

Synopsis/HPI: Patient is here for sneezing, allergies and sore throat. She has been with symptoms one day. She notes sinus pain as well.

Skin: burns to left leg and has occ low back pain, she has varices as well

Review Of Systems: Non-Contributory except for that in the HPI

Physical Exam:

BP: 92 / 60 P: R: T: 99 WT: 143 Ht:

GEN: Well-nourished individual in no acute distress.
SKIN: varices to legs
HEENT: No lesions to eyes, ears , nose or throat, sinus pain upon palpation
NECK: No adenopathy.
CV: RRR, no murmurs.
LUNGS: Clear to auscultation, no rhonchi, no wheezing.
ABDOMEN: Soft, nontender, nondistended.
NEURO: CN II- XII intact.
MUSCULOSKELETAL: No abnormalities.

Diagnoses:

454.9	Varicose Vein of Leg
473.9	Sinusitis
477.9	Allergic Rhinitis
729.5	Leg Pain

Procedures:

J0696	Rocephin 500 mg
	depomedrol 40mg IM

Plan:

Sinusitis - 473.9

— Amoxil 500 mg Sig: 1 Capsule q8h (Every 8 Hours) for 7 days.. NO REFILLS.

Allergic Rhinitis - 477.9

— Allegra 60 mg Sig: 1 Tablets BID (Twice Per Day) Disp. # 60. NO REFILLS.

— Flonase 50 mcq/spray Sig: 1 Nasal spray each nostril once a day Disp. # 1. NO REFILLS.

Patient Discussion: due for mmg, colon screen and pap

Patient: **VIRGINIA VELEZ**
36196 - 1/31/1958
9415 QUAIL MEADOW DR
Austin, TX 78758

36196

Belda Zamora MD

2100 E. 6th Street
Austin, Texas 78702
(512) 474-7824

may use aspercreme to legs for burning feeling

Belda Zamora MD

CLINICA MATERNIDAD FATIMA

Dr. J. Elias Miguel Ch.

U.A.G. Ced- Prof. 1446691 SSA2839

Horario Clinica Fatima: Lunes - Viernes de 15:00 a 21:00

URGENCIAS: CEL. 626-4820

CLINICA FATIMA
AV. EL GRANJERO # 7022-1
FRACC. OASIS
TEL. 620-1466

CONSULTORIO PARTICULAR
JILOTEPEC # 7629
ESQ. CON GROCELLA
INF. AEROPUERTO
TEL.637-1284
CEL. (656) 626-4820

NOMBRE Virginia Vaca FECHA 18 marzo 20

Rx

1 amp. Atin

Aplicar 1. M. dosis única

1 caja Alloga 180 mgs

tomar 1 diaria

por 7 días

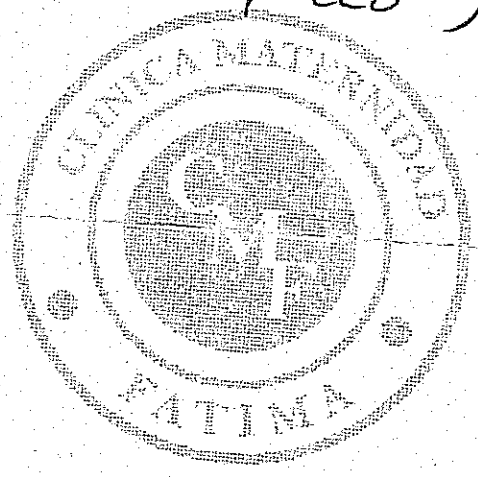
SURTA SU RECETA EN:
FARMACIA FATIMA
TEL. 620-1594
AV. EL GRANJERO # 7022-2
SI ES MEDICAMENTO CONTROLADO
DEBE ESTAR SELLADA

DESCUENTO PERMANENTE EN MEDICAMENTOS DEL 10 % AL 20 %

EVITAR

- FRESA
- CHOCOLATE
- LACTEO
- HUEVO
- POLLO

} 5 días



RINITIS ALERGICA.

PUBLIC HEARING INFORMATION

Although applicants and/or their agent(s) are expected to attend a public hearing, you are not required to attend. However, if you do attend, you have the opportunity to speak FOR or AGAINST the proposed development or change. You may also contact a neighborhood or environmental organization that has expressed an interest in an application affecting your neighborhood.

During a public hearing, the board or commission may postpone or continue an application's hearing to a later date, or recommend approval or denial of the application. If the board or commission announces a pecific date and time for a postponement or continuation that is not later than 60 days from the announcement, no further notice is required.

A board or commission's decision may be appealed by a person with standing to appeal, or an interested party that is identified as a person who can appeal the decision. The body holding a public hearing on an appeal will determine whether a person has standing to appeal the decision.

An interested party is defined as a person who is the applicant or record owner of the subject property, or who communicates an interest to a board or commission by:

- delivering a written statement to the board or commission before or during the public hearing that generally identifies the issues of concern *(it may be delivered to the contact person listed on a notice)*; or
- appearing and speaking for the record at the public hearing;

nd:

- occupies a primary residence that is within 500 feet of the subject property or proposed development;
- is the record owner of property within 500 feet of the subject property or proposed development; or
- is an officer of an environmental or neighborhood organization that has an interest in or whose declared boundaries are within 500 feet of the subject property or proposed development.

A notice of appeal must be filed with the director of the responsible department no later than 10 days after the decision. An appeal form may be available from the responsible department.

For additional information on the City of Austin's land development process, visit our web site: www.ci.austin.tx.us/development.

Written comments must be submitted to the board or commission (or the contact person listed on the notice) before or at a public hearing. Your comments should include the name of the board or commission, or Council; the scheduled date of the public hearing; the Case Number; and the contact person listed on the notice.

Case Number: C15-2010-0055 – 9415 Quail Meadow Dr
Contact: Susan Walker, 512-974-2202
Public Hearing: Board of Adjustment, June 14, 2010

Charles Adams

☐ I am in favor
☒ I object

Your Name (please print)

9504 Gamble Quail Dr

Your address(es) affected by this application

Charles Adams 10/10/10

Signature *Date*

Daytime Telephone: 512-636-4587

Comments: Addition would be used to house other tenants, possibly transients. Space is not adequate enough to accomodate this add-on development could create hard to the original neighborhood plan.

If you use this form to comment, it may be returned to:
City of Austin-Planning & Development Review Department/ 2nd Floor
C/O Susan Walker
P. O. Box 1088
Austin, TX 78767-8810

P.S. And the house down the street does not have a Pool

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- appearing and speaking for the record at the public hearing;

and:

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- is the record owner of property within 500 feet of the subject property or proposed development; or
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Case Number: C15-2010-0055 – 9415 Quail Meadow Dr
Contact: Susan Walker, 512-974-2202
Public Hearing: Board of Adjustment, June 14, 2010

Carolyn D Smith
Your Name (please print)

☐ **I am in favor**
☒ **I object**

9502 Gambels Quail Dr.
Your address(es) affected by this application

Signature *Date*

Daytime Telephone:

Comments: no more duplexes!

If you use this form to comment, it may be returned to:
City of Austin-Planning & Development Review Department/ 2nd Floor
C/O Susan Walker
P. O. Box 1088
Austin, TX 78767-8810